

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 2 1 2 6 3 1 REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA TANN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 20 82 | | | | | |
| 3 SEX F | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 10 29 27 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | 2b. HOUR 14 D ^M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE BALT. MD | | | | | 13b. COUNTY BALT. | | 13c. CITY OR TOWN BALT. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PERCY HARGROVE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH JANE BELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 239-40-5217 | | 17. INFORMANT ADDRESS HUBBARD TANN 1454 MOUNT MOR CT. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>Disseminated Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c). 1990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Malnutrition</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>82</u> , to <u>5/20</u> , 19 <u>82</u> , that (1) (we) lost saw the deceased alive on <u>5/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Edward J. Bessman MD</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 5/20/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BESSMAN | | | | | 22e. ADDRESS University Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Bell Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Olive N.C. | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March E/H | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1982 | | 25b. REGISTRAR'S SIGNATURE <u>James Van Natta</u> | |

10021 88

7113



SECTION



W. C. ...
...

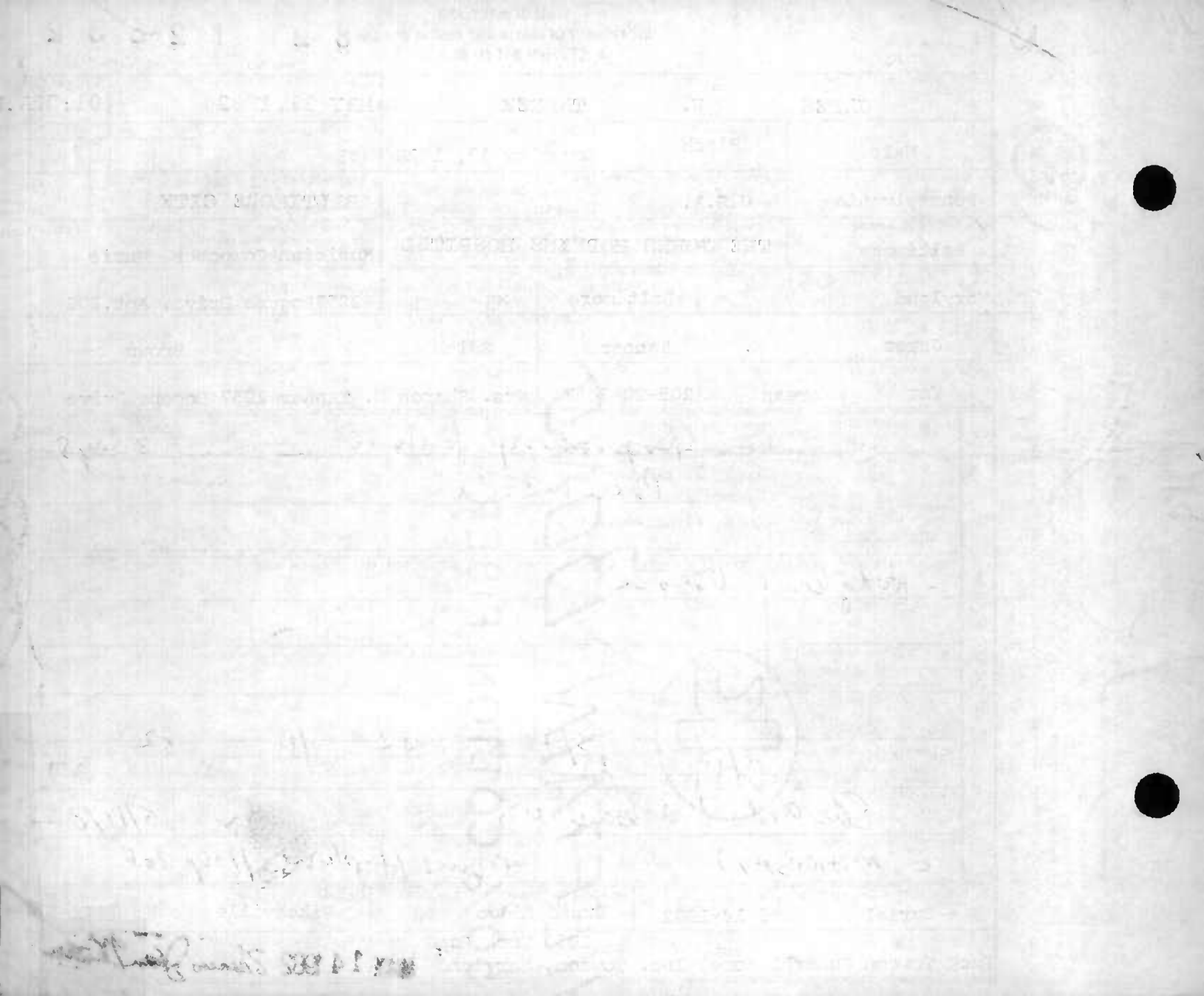
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| JAMES W. TANNER | | MAY 11, 1982 | |
| 3. SEX | | 4. RACE | |
| Male | | Black | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| November 17, 1928 | | 53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| Pennsylvania | | U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| | | BALTIMORE CITY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | |
| Baltimore | | THE JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Musician-Composer | | Music | |
| 13a. STATE | | 13b. COUNTY | |
| Maryland | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| James W. Tanner | | Edith Brown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Yes | | 205-20-8497 | |
| 17. INFORMANT | | ADDRESS | |
| Mrs. Sharon M. Tanner | | 2257 Rogene Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | 3 days | |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| <u>Hodgkin's disease</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> 19 <u>82</u> to <u>5/11</u> 19 <u>82</u> , that (I) (we) lost | | | |
| saw the deceased alive on <u>5/11</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | |
| Eduardo Marban MD | | 5/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| E. MARBAN | | Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Burial | | 5-14-1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Druid Ridge | | Pikesville Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25. DATE REC'D. BY REGISTRAR | |
| Ruck Towson Funeral Home, Inc. Towson, Maryland | | MAY 14 1982 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department within one hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 6 3 3 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL M. BEEMAN - TAPSCOTT | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/3/82 | | 2b. HOUR 1:55 AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 18 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN DUNDALK | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2002 PAULETTE RD. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BRADLEY BRANSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE NAPIER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) - | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS JUANITA VALLEJO 6226 ALUMORE WAY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cordis pulmonarum omisit 1639 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic lung ca. DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) - | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1/82 19, to 5/3/82 19, that (I) (we) last saw the deceased alive on 5/3/82 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C R T B B W | | | | 22e. ADDRESS B C H | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 6 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE | | 23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD COUNTY MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS CONNELLY FUNERAL HOME OF DUNDALK | | | | 25a. DATE REC'D. BY REGISTRAR MAY 4 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

ST-EL M DEEMAY - JASCOOT

Female White

Knicker 1

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

LA-O-CITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 3 4
REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lillian TATE | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-16-82 | | | 2b. HOUR M | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 1-17-18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN HOPKINS HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1111 PARK AVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Will Leo | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Tucker | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT George Rawling | | | | ADDRESS 1111 PARK AVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (c) WITH ATRIAL FIBRILLATION + CONGESTIVE HEART FAILURE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 6 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from JANUARY 1967 to MAY 16 1982, that (I) lost saw the deceased alive on APRIL 15 1982, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) viewed (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Carlton L. Sexton, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-17-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carlton L. Sexton, M.D. | | | | | | 22e. ADDRESS Baltimore Life Building 901 N. Howard Street, Baltimore, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | |
| 24. FUNERAL DIRECTOR NAME Vernon R. Bailey | | | | | | ADDRESS 1348 N. Calhoun St. | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | |
| 25b. REGISTRAR'S SIGNATURE Theresa J. [Signature] | | | | | | | | | |

U. S. 1 2 0 0 1

5 MONTHS

Various other things in common interest
with the 7 division
and the 10 division



THE DAY 17

2-17-82

Carlton L. ...
1001 E. Howard Street, Baltimore, MD 21201
Baltimore Life Building

MAY 11 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 6 3 5 | |
|--|--|---|--|---|---|----------------------------------|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN TAYLOR | | | | | 2a. DATE OF DEATH MONTH 5 / DAY 4 / YEAR 82 | | | | | 2b. HOUR 4:10 P.M. | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 1 / DAY 1 / YEAR 04 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Charles Gen. Hosp. | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Lake Drive N. H. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn. | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237-26-3970 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT (CVA) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) SEIZURE DISORDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7 19 82 to 5/4 19 82 , that (I) (we) last saw the deceased alive on 5/4 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A.C. Chevalier, M.D. | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHEVALIER, M.D. | | | | | 22e. ADDRESS NORTH CHARLES GENERAL HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 5/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | | | | |

C. G. C. 2. 1

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1910

1910

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 6 3 6 | | |
|--|--|------------------------------|--|---|--|--|---|--|-----------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| CLIFFORD LEE TAYLOR | | | | | | MAY | | | 28 82 | | 3:15P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | | White | | MONTH DAY YEAR Jan 12, 1922 | | 60 YRS | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| West Virginia | | USA | | | | BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | | VAMC LOCH RAVEN BLVD. BALTO. MD | | | Carpenter | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | | A.A.Co. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 29 Kempton Rd. Glen Burnie, Md. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | |
| Everett Taylor | | | Delia Stuckey | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | | W.W. 2 | | Mrs. Gloria L. Taylor, Same as above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> | | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 25</u> , 19 <u>82</u> , to <u>May 28</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 28, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| Edmond Bessman MD | | | | | | | | | 5/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | |
| BESSMAN | | | 3900 Loch Raven Blvd. Balto. Md. 21218 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | | June 2, 1982 | | Glen Haven Mem. Park | | Glen Burnie, A.A.Co. Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| McCutty Funeral Home, Mt. & Tickneck Rds. Pasadena, Md. 21122 | | | JUN 3 1982 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 6 | 3 | 7 |
|---|--|--|--|---|---|--|---|---|--|---|--|---|---|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD ALLEN TAYLOR SR. | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-20-82 | | | | 2b. HOUR 5²⁰ P^M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 12 40 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 41 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTENDANT | | | 12b. KIND OF BUSINESS OR INDUSTRY CLUB | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1608 COLE STREET. | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROY TAYLOR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA VICTORINE | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 217-38-8787 | | 17. INFORMANT ADDRESS THERESA D. TAYLOR 347 S. MOUNT ST. 21223 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-82 to 5-20-82 , that (I) (we) lost saw the deceased alive on 5-20-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Cesar Vinuesa | | | | | | DEGREE | | 22c. DATE SIGNED 5-20-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR A. VINUEZA | | | | | | |
| 22e. ADDRESS ST. AGNES HOSPITAL | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 05-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | | | ADDRESS 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE Theresa D. Taylor | | | | | | |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Daniels Taylor | | | 2a. DATE OF DEATH MONTH DAY YEAR May 23, 1982 | | 2b. HOUR 8:15 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 21, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1106 Bellemore Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Schoolteacher | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY City | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME John Henry | | | 15. MOTHER'S MAIDEN NAME Sarah Knepper | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 209-20-3412 | | 17. INFORMANT Carl Taylor, Same As #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 1889 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 42 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 19 28, to May 19 82, that (I) (we) lost the deceased alive on May 20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE W B Daniels, Jr. | | DEGREE M.D. | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 5/24/82 |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Worth B. Daniels, Jr. M.D. | | 22f. ADDRESS 11 E Chase Street, Baltimore, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-28-82 | | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Huntingdon, Pennsylvania |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | ADDRESS 1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |

0001

11

1



SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 2 6 3 9 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETTA M. TAYLOR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1982 | | 2b. HOUR 10 35P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 8th, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. Balto. | | | | | 13b. CITY OR TOWN Rogers Forge | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 208 Rodgers Forge Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John J. Kelly | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester E. Armstrong | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-9595 | | 17. INFORMANT ADDRESS Mrs. Esther Taylor Moran-116 Homeland Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4280 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 17, 1982, to May 17, 1982, that (I) (we) lost saw the deceased alive on May 17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Richard A. Lebow MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 05-17-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. Lebow | | | | | 22e. ADDRESS Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto City | | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR SIGNATURE Name of Registrar | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with #22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 4 0

REG. NO.

| | | | | | | |
|--|--|--|--|---|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES ZACHARY TAYLOR, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 05/27/82 | | 2b. HOUR 9:25am | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 31 22 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 59 | | IF UNDER 24 HRS. HOURS MIN. 9:25am | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH BALTO CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production Sup. | | 12b. KIND OF BUSINESS OR INDUSTRY Lion Brothers | | 13a. STREET ADDRESS 2241 Southland Road | | |
| 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert A. Taylor | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace L. Trott | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 11 | | |
| 16b. SOCIAL SECURITY NO. 218-14-3500 | | 17. INFORMANT Mrs. Gene E. Taylor | | ADDRESS 2241 Southland Rd., Baltimore, MD 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/26 82 , to 5/27 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 5/27 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above (I/we) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Lillian L. Hicken | | DEGREE MD | | 22c. DATE SIGNED 5/27/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM J HICKEN MD | | 22e. ADDRESS St Agnes Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Rd., Randallstown, MD 21133 | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE James E. Nathan | | |

0 7 9 1 2 0

02/07/82 9:32am

TAYLOR

(SAC/AD)

2284

WILLIAM

SALE CITY

11/11/82

11/11/82



08

1510

01

0212

08

WILLIAM S. ROSS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 6 | 4 | 1 |
|---|--|--|--|--|--|--|--|--|---|---|---|--|---|------------------|---|---|
| 1 - STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | |
| FIRST MIDDLE LAST Lewis LOUIS P. TAYLOR | | | | | | | | | | MONTH DAY YEAR HOUR 5- 1 82 1:55 PM | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | | | White | | | MONTH DAY YEAR 5 24 29 | | | 52 YRS. | | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Pa. | | | U.S.A. | | | | | | BALTIMORE CITY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | |
| BALTIMORE | | | UNION MEMORIAL HOSPITAL | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Salesman-First Nat. Builders | | | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | |
| Md. | | | Balto. | | | Balto | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 5108 Belair Rd. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | |
| Lewis G. Taylor | | | | | | Margaret McLain | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | | | | |
| No | | | | | | Frank Taylor 5108 Belair Rd. #21206 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE CVA's, (R) THALAMIC HEMATOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRESUMED ASCVD 2° HEAVY SMOKING</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>82</u> , to <u>5/1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Carl Sperling M.D.</u> | | | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>5/1/82</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CARL SPERLING, M.D.</u> | | | | | | 22e. ADDRESS <u>201 E UNIVERSITY PARKWAY Balto 21218</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Cremation | | | 5-4-82 | | | Westview Cemetery | | | Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>G. Truman Schwab, P.A.</u> | | | | | | ADDRESS <u>3512 Frederick Ave. #21229</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 10 1982</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Francis J. [Signature]</u> | | | | |

8 2 1 2 0 4 1

TAYLOR

B.

LOUIS

LOUIS

Miss

Miss

U.S.A.

U.S.A.

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

Department of Medicine

Miss

Miss

Miss

Taylor

Taylor

Taylor

Frank Taylor 2108 Belmont Rd. Baltimore

WILLIAMSON COLLECTION



BP_____

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|-------------------------|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael Franklin Taylor | | LAST | | 20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 7 1982 | | 2b. HOUR M P | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 15, 1946 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS. | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 7 1982 | 7d. HOUR M P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Lighting |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Melvin Taylor | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Shamen | | 13e. STREET ADDRESS 1051 Locust Lane 21122 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No - - - | | 16b. SOCIAL SECURITY NO. 214-48-0966 | | 17. INFORMANT ADDRESS Mrs. Lillian Taylor Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 11:36 P.M. 4 28 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) trailer driver of auto that struck parked tractor/ | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 3 nr. Brightview Rd, Annapolis, A.A.Co, MD | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER DATE SIGNED 5/8/82 | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel, Md. | |
| 24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Pasadena | | | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE Shane O. Smith | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 6 4 3
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| OLIVER | | TAYLOR | | MAY 11, 1982 | | 12:07AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Black | | 3 16 29 | | 53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| North Carolina | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | THE JOHNS HOPKINS HOSPITAL | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| MD | | Baltimore | | | | 1671 Cliftview Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Roy Taylor | | Mattie Battle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 217-26-3707 | | Jean M. Taylor | | 1671 Cliftview Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 4354 | | Cardiac Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Idiopathic cardiomyopathy | | 15 years. | | | |
| | | (c) hypertension, alcoholism | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1975, 19 1982, to May 11, 19 82, that (I) (we) last saw the deceased alive on May 11, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| W. G. McKenna | | M.D. | | May 11 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| MCKENNA | | Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/14/82 | | Eastview Mem. Pk. | | Balto. MD | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| William C. March Funeral Home | | MAY 14 1982 | | Johns Hopkins | | | |

1301

1301

1301

1301

1301

1301

1301



1301

1301

1301

1301

1301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 11 per phone 5/24/82 dad | | | | STATE OF MARYLAND | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 2 6 4 4 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT E. TAYLOR JR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 17, 1982 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) home 3335 Elm Ave. 21211 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman. | | 12b. KIND OF BUSINESS OR INDUSTRY R.R. | |
| 13a. STATE Md. | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Taylor Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Baker | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes. | | | | 16b. SOCIAL SECURITY NO. W.W.II 213-09-2080 | | 17. INFORMANT ADDRESS Betty I Taylor 3335 Elm Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10): <u>Anemia & Myeloproliferative Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from <u>8-13-79</u> to <u>5-17-82</u> , that (I) (we) lost saw the deceased alive on <u>5-17-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Miriam L. Chenoweth MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miriam L. Chenoweth MD | | | | 22e. ADDRESS 201 E. University Pkwy. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Paul E. Chenoweth. | | | | ADDRESS 3615 Chestnut Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. Patten | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2222.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 6 4 5 | |
|--|--|---|---|---|--|--|---|---|---|---|--|
| FOR 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Concetta M. Teramani | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 10, 1982 | | | 2b. HOUR M M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 8, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3833 Yolando Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3833 Yolando Rd | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Pulverenti | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 216-05-7471 | | 17. INFORMANT Mr P. Thomas Teramani | | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy 4360 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis yes. DUE TO, OR AS A CONSEQUENCE OF (c) Body Total Contracture 10+ yrs. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Multiple Ingested Toxiculosis (yrs) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 01-05 , 19 82 , to 02-02 , 19 82 , that (I) (we) lost saw the deceased alive on 02-02 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard Tyson, M.D. | | | | | DEGREE MD. | | | 22c. DATE SIGNED 05-10-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Tyson, M.D. | | | | | 22e. ADDRESS 936 W. North Ave. Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Entombment | | | 23b. DATE 5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Maus. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

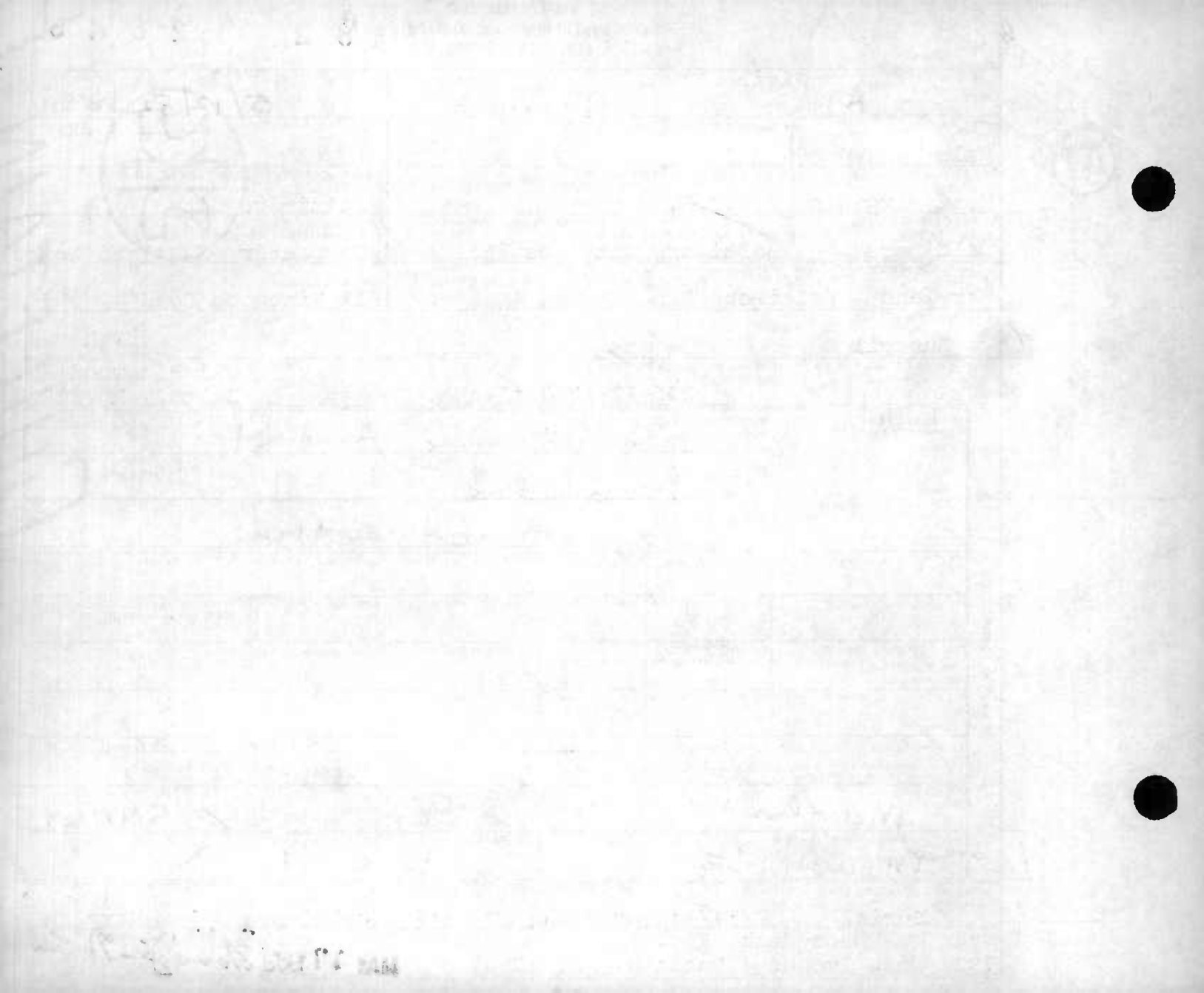
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 4 6

REG. NO.

| | | | | | | |
|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alvin R. Thomas | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/12/82 | | 2b. HOUR 800 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 6 1913 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | 12b. KIND OF BUSINESS OR INDUSTRY Ryland Homes | | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Russell Thomas | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Luzier | | 13d. STREET ADDRESS 311 Pinewood Road | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 236-12-1707 | | 17. INFORMANT ADDRESS 311 Pinewood Rd. Balto., MD. 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 82 , to 5/12 , 19 82 . That (I) (we) last saw the deceased alive on 5/12 , 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE M. Welin | | DEGREE | | 22c. DATE SIGNED 5/12/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Welin | | 22e. ADDRESS B.C.M. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/17/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Population be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 6 | 4 | 7 |
|---|--|--|--|--|--------------------------|--------------------------------------|------------------------------------|--|----------------------------|--|---|-----------------------------------|---|----------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| ANTHONY (BABY BOY) THOMAS | | | | | | | | | | MAY 27, 1982 | | | | 2:15a | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | |
| Male | | Black | | 5 MONTH 4 DAY 82 YEAR | | YRS. | | MONTHS 23 | | DAYS 23 HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| MD | | USA | | | | BALTIMORE CITY MD | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | JOHNS HOPKINS HOSPITAL | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | | |
| MD | | | | | | | | | | Baltimore | | 1307 N. Dallas St. | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| Bobby Cannon | | | | | Patricia Thomas | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| No | | | | | N/A | | Patricia Thomas 1307 N. Dallas St. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 7789 Cardio-Respiratory Arrest | | | | | | | | | | 10 min | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis with Neutropenia | | | | | | | | | | 5 days | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity And Skin Disorder | | | | | | | | | | 23 days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | |
| Thrombocytopenia, Patent Ductus (Ligated) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/17, 1982, to 5/27, 1982, that (2) (we) last saw the deceased alive on 5/27, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | |
| [Signature] | | | | | | | | | | 5/27/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | |
| Daniel Goldstein | | | | | | | | | | Johns Hopkins Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| Burial | | | | 6/1/82 | | Eastview Mem. Pk. | | | | Baltimore MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | JUN 3 1982 | | | [Signature] | | | | | | | |

NOV 11 1944

RECEIVED

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

NOV 11 1944

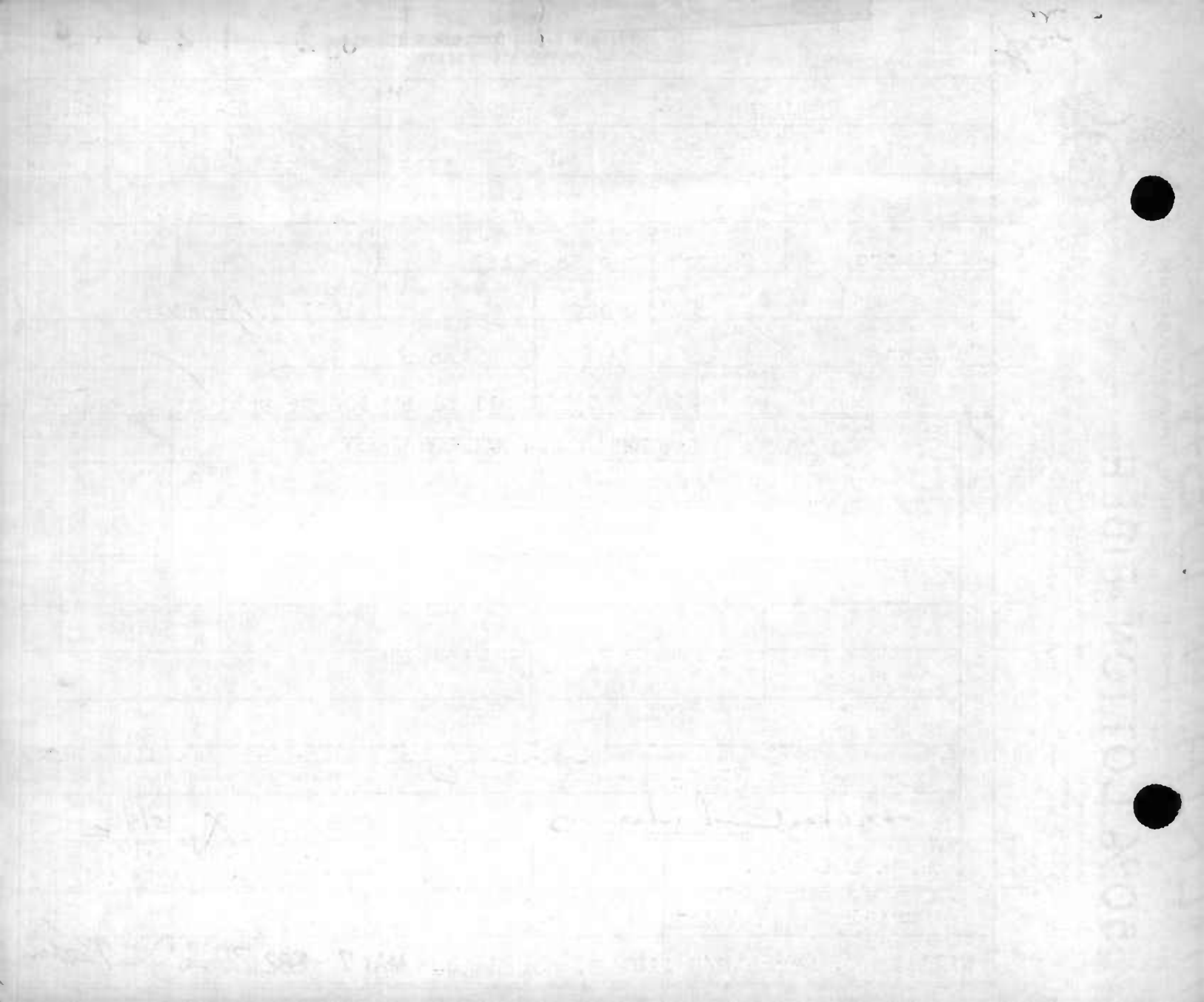
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 4 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENJAMIN H. THOMAS | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-03-82 | | 2b. HOUR 9:55pm |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 1 15 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 228-24-5125 | | 17. INFORMANT ADDRESS Dell Clark 906 St Paul St Richmond Va | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05-03-1982 , to 05-03-1982 , that (I) saw the deceased alive on 05-03-1982 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Michael L. Lohar</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. M. LUHAR M.D. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery Baltimore | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | 23e. DATE REC'D. BY REGISTRAR (DATE REGISTRAR'S SIGNATURE) MAY 7 1982 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave. | | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 4 9

1- FOR
STATE REGISTRAR John H. Thomas

REG. NO.

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John HARRY THOMAS SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-27-82 | | 2b. HOUR 8:45 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 11, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 84 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher | | 12b. KIND OF BUSINESS OR INDUSTRY Heinz Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-09-0014 | | 17. INFORMANT ADDRESS Lillian K. Noel (same as 13e) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA, 2nd stage to Brain DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 3 DAYS. UNDETERMINED | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic cardiovascular Disease | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22/82 19 82 to 5/27/82 19 82 , that (I) (we) last saw the deceased alive on 5/22/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/27/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. MIRANDA, MD | | | | 22e. ADDRESS PROVIDENT HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce F.H. 4001 Ritchie Hgwy. Balto., Md. 21225 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 2 1982 [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



8 2 1 2 6 5 0

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 20. DATE OF DEATH | | REG. NO. | |
| MARSHALL Francis THOMAS | | | | 05 18 82 | | 0901 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | Negro | 7 MONTH 4 DAY 28 YEAR | | 53 YRS. | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | | | BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | JOHNS HOPKINS HOSPITAL | | | Traffic Mang. | | Lettercraft | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Frederick | | Frederick | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 304 W. South Street | | | |
| Ralph Charles Thomas Sr. | | Marie Gertrude Barnes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| Yes | | WWII | | 222-13-1378 Barbara Thomas Frederick | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | 5 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>liver metastases</u> | | | | | | | 1 month |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>colonic adenocarcinoma</u> | | | | | | | 4 years |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| NA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| N/A | | N/A | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| N/A | | P.M. N/A 19 | | N/A | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, PLACE OF WORK, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| N/A | | N/A | | N/A | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>4/23</u> , 19 <u>82</u> , to <u>5/18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| L. Widman | | | | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| L. WIDMAN | | | | JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/22/82 | | Fairview Cemetery | | Frederick, Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | |
| G. Douglas Stauffer Frederick, Maryland | | | | | | | |

SSS-13-1378

orgel

1000

5,

55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 2 6 5 1 REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Rachel | | MIDDLE - | | LAST Thomas | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 14 1982 | | 2b. HOUR 9 54 AM | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 2-15-15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1665 Argyle Ave | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST T. Sack E. Fisher | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Tyler | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS LAURENE Fisher 1065 Argyle Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Medical Examiner's Case</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART I (OR PART 2)) | | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that if this hospital attended the deceased from the time the deceased alive on _____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) I did not view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE Arthur J. Komant MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur J. Komant MD | | 22b. ADDRESS 22 S. Greene St. Baltimore, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY STATE Md | | | |
| 24. FUNERAL DIRECTOR NAME Vernon R. Bailey | | ADDRESS 7348 N. Calhoun St | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

9 9

BP

1 2 3 4 5 6



Vertical text or stamp on the left side of the page, possibly a date or reference number.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 6 5 2 REG. NO. | | | | |
|--|--|--|--|--|--|---|--|----------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) Jeffrey (Jeffery) O. Thompson | | | | 5 1 1982 | | | | M |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 1963 | | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3513 Virginia Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3513 Virginia Ave | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sy Thompson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane R. Reed | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Sy Thompson 2800 Ashland Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) DUCHENNE MUSCULAR DYSTROPHY DUE TO, OR AS A CONSEQUENCE OF (c) 3591 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/30 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/30 1982 to 5/1 1982 that (I) (we) lost saw the deceased above (If not, did not view the body after death). | | | | | | | | |
| 22b. SIGNATURE Leon E. Kassel, MD DECEASED ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5/4/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEON E. KASSEL MD | | | | 22e. ADDRESS SINAI HOSPITAL, Balt, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR SIGNATURE May 5 1982 | | | | |

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12653 | |
|--|--|------------------|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST RICHARD JOSEPH TIEKEWSKI | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-30-82 | | | 2b. HOUR M 7:29 a.m. | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 - 9 - 1925 | | 6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-30-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1412 W. Lombard Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSEMBLER | | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL MFR. | |
| 13a. STATE MARYLAND | | | 13b. COUNTY ----- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1412 W. LOMBARD ST. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | (IF YES, GIVE WAR OR DATES) NAVY WW1 | | 16b. SOCIAL SECURITY NO. 148.18.1752 | | 17. INFORMANT ADDRESS 2111 HOLLY AVE. THERESA MANIONE ARCADIA, CALIF. 91006 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 5-30-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 6/3/1982 | | 23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETERANS CEM. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE | | |
| 24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. | | | | | | ADDRESS DUNDALK, MD. 21222 | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | |

50% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | Items, 23d. & 1, Film G-567, DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 6 5 4 | |
| 5/28/82 / By F.H.D., G.B.J. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (Type or Print) | | Tirpac | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| John | | Tirpac | | 5/20/82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Male | | White | | 6/1/21 | |
| 7a. BIRTHPLACE (State or Foreign Country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. AGE (In Years (Last Birthday)) | |
| PA. | | USA | | 61 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | University Hosp | | Baltimore city MD | |
| 12a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) | | 12b. USUAL OCCUPATION (Type or Print) | | 12c. KIND OF BUSINESS OR INDUSTRY | |
| MD | | Balt city | | Retail Store Manager | |
| 14. FATHER'S NAME (Type or Print) | | 15. MOTHER'S MAIDEN NAME (Type or Print) | | 13a. STREET ADDRESS | |
| Stephen Tirpac | | Sophia Huzinec | | 9 E Lafayette Ave | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, include service) | | 16b. SOCIAL SECURITY NO. | | 12. INFORMANT (Type or Print) | |
| Yes | | 191 189482 | | Mrs Margaret Tirpac | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4413 | | cardioresp rest 2° exsanguination | | | |
| Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) ruptured abd aortic pseudocyst. | | | |
| | | (c) necrosis of aortic wall | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| renal failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5/20/82 | | abd aortic aneurysm | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) | |
| 40 | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20/82 to 5/20/82, that (I) (we) last saw the deceased alive on 5/20/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE (Type or Print) | | DEGREE | | 22c. DATE SIGNED | |
| Catherine S May MD | | M.D. | | 5/20/82 | |
| 22d. PHYSICIAN'S NAME (Type or Print) | | 22e. ADDRESS | | | |
| Catherine S May MD | | 22 S Greene St | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/22/82 | | St. Nicholas | |
| 23d. LOCATION (City or Town) | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Perry Township Fayette Baltimore, Maryland Penna. | | MAY 21 1982 | | Thomas J. W. [Signature] | |
| 24. FUNERAL DIRECTOR (Name) | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J Ruck Inc. Baltimore, Maryland | | MAY 21 1982 | | Thomas J. W. [Signature] | |

202

2

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 2 6 5 5 | | |
|---|--|--|--|--|--------|---|-------------------|--|-------|--|------|-----------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| | | CLARENCE | | | | 10 80 | MAY 25 '82 | | | | | 11 05 A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | Negro | | 1 MONTH 24 DAY 1928 | | 54 YRS | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | USA | | | | Baltimore City, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Mercy Hospital | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Midtown Nursing Home | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | |
| Unkn | | | | Unkn | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | N/A | | Edna Snead 201 N. Broadway Apt 7N | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) 3441 CARDIO PULMONARY ARREST | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) PARAPLEGIA | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/24/82, 1982, to 5/25, 1982, that (I) (we) lost saw the deceased alive on 5/25/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | |
| 7/25/82 | | MD | | | | 5/25/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | |
| LARRY FELDMAN | | | | MERCY HOSP - BART, MD 20212 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | |
| Burial | | 6/1/82 | | Mt. Zion Cemetery | | Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | JUN 3 1982 | | | | James J. Nathan | | | | |



U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner(s) must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 5 6

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) GRACE Windsor TODD | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1982 | | 2b. HOUR 12 ³⁰ P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9-25-1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Worcester County | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WEL NURSING HOME B.C.H. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Companion | | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Windsor | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-26-4790 | | 17. INFORMANT ADDRESS Robert W. Todd - 5925 Ayleshire Rd. -21239 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dementia (Alzheimer's); Recurrent pneumonias | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 Nov 76 , 19 82 , to 4 May , 19 82 , that (I) (we) last saw the deceased alive on 4 May , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Edmunds Beacham MD | | DEGREE MD | | 22c. DATE SIGNED 4 May 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. G. BEACHAM MD | | 22e. ADDRESS BALTIMORE CITY HOSPITALS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | |

1. *[Faint, illegible text]*
2. *[Faint, illegible text]*
3. *[Faint, illegible text]*
4. *[Faint, illegible text]*
5. *[Faint, illegible text]*

6. *[Faint, illegible text]*
7. *[Faint, illegible text]*
8. *[Faint, illegible text]*
9. *[Faint, illegible text]*
10. *[Faint, illegible text]*

11. *[Faint, illegible text]*
12. *[Faint, illegible text]*
13. *[Faint, illegible text]*
14. *[Faint, illegible text]*
15. *[Faint, illegible text]*

16. *[Faint, illegible text]*
17. *[Faint, illegible text]*
18. *[Faint, illegible text]*
19. *[Faint, illegible text]*
20. *[Faint, illegible text]*



75a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE
JUN 3 1982 James Van Natten

10001 - 0

1/



10001 - 0

10001 - 0

10001 - 0

10001 - 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 6 5 8 REG. NO. | |
|--|--|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIA TOPALTZAS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-8-82 | | | 2b. HOUR 11a.m. | | | |
| 3. SEX FEMALE | | 4. RACE C | | 5. DATE OF BIRTH MONTH DAY YEAR 6 28 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK Greece | | 7b. CITIZEN OF WHAT COUNTRY? ✓ ? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY - | | 13c. CITY OR TOWN - | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2525 W. BELVEDERE AVE. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kostanine - UNK Moskovis | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Asimina UNK Kazaras | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-56-944 | | 17. INFORMANT ADDRESS CHART 1436 Pleasant Valley Drive (28) Steve Kinigopoulos | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (b) Old age, Ca Colon | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-6-19-82 , to 5-8-19-82 , that (I) (we) lost saw the deceased alive on 5-8-19-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sheila Ebenezzer | | | | DEGREE MBBS | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEILA EBENEZER | | | | | | 22e. ADDRESS SINAI HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS G. Truman Schwab 5151 Balto. National Pike Balto. Md. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 13 1982 <i>James J. Nathan</i> | | | | | |

BP

000000

Confronting

divolacK

animal

0014503

1945 Pleasant Valley Drive (23)

22

10:17 PM

2001, 11, 1985

Journal of Interpersonal Violence

100

1. The above information is true and correct.

0551 . 47 . 21

3
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 2 6 5 9 | | | |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Viola Torney | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-04-82 | | 2b. HOUR 3:35 PM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 03-29-01 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS 834 Edmondson Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212423925 | | 17. INFORMANT JAMES PORTER 2415 W. LANVALE ST ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 2506 DUE TO, OR AS A CONSEQUENCE OF (b) Gangrene of toes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3/82 to 5/4/82 , that (I) (we) lost saw the deceased alive on 5/4/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Agout | | DEGREE | | 22c. DATE SIGNED 5/4/82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KVAV NYUNT | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-8-82 | | 23c. NAME OF CEMETERY OR CREMATORY Town Neck Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Severna A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME Charles A. Rice | | ADDRESS 35PA 1300 Eutam | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

10-17-51

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12660 | | | | | | | | | |
|---|--|------------------|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD B. TOSTEN | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 10 1982 | | 2b. HOUR 7:15 | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH (MONTH DAY YEAR) Feb. 18, 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY) 22 Yrs | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 5 10 1982 | | 2d. HOUR a M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep. | | | | 12b. KIND OF BUSINESS OR INDUSTRY Tool Co. | | | | | | | |
| 13a. STATE Penna. | | | | | | | | | | 13b. CITY OR TOWN Chambersburg | | 13c. STREET ADDRESS 3830 Wenger Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LESTER M. TOSTEN | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONSTANCE SCHAFF 17201 | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No. | | | | 16b. SOCIAL SECURITY NO. 173-56-5949 | | | | 17. INFORMANT ADDRESS Mr. Lester M. Tosten Chambersburg, Pa. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Traumatic injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 8:10 P.M. 5-9- 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto that lost control. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Pa. Rt. 416 Franklin Pa. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Accident</u> <input checked="" type="checkbox"/> <u>Natural causes</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-10-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Gardens | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Greene Twp. Franklin Co. Penna. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home | | | | ADDRESS Reisterstown, Md. 21136 | | | | 25a. DATE REC'D BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | | | | | | | | | |

MEDICAL CERTIFICATION

000 : 1

Item 7a g568 6/2/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 6 1

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE Rita TRABONA | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 03 1982 | | 2b. HOUR 10:10AM |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1 1 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) New York City | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Research |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Frederick | 13c. STREET ADDRESS 8412 Stonehouse Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Nezi | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Silvestri | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 131-20-8986 | | 17. INFORMANT Vincent Trabona Frederick, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Diabetes | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 82 , to 5/3 , 19 82 , that (I) (we) last saw the deceased alive on 5/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gelman | | DEGREE MD | | 22c. DATE SIGNED 5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gelman | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gar. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME G. Douglas Stauffer Frederick, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | |

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the physician who attended the deceased.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician, it should be completely filled in by the funeral director and completely filled in by the funeral director. The funeral director should be detached for use as the burial-transit permit. The funeral director should be detached for use as the burial-transit permit. The funeral director should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

LYNN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 6 2

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Carl J. Trent | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 7 1982 | | | 2b. HOUR 7:20 AM | | | | |
| 3. SEX Male | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 12 06 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 505 S. Vincent Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Storm Windows | | |
| 13a. STATE MD | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 636 Aldershot Drive, 2122 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Van Jackson Trent | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Grady | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWII | | | 16b. SOCIAL SECURITY NO. 217-26-5496A | | 17. INFORMANT Mrs. Mildred Trent | | ADDRESS 505 S. Vincent Ave. Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) COR PULMONALE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 5 YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COR PULMONALE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 23 , 19 80 , to APRIL 28 , 19 82 , that (I) (we) lost saw the deceased alive on APRIL 28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE ANASTASIO R. DE CASTRO | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/7/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTASIO R. DE CASTRO | | | | 22e. ADDRESS ST AGNES HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 5/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 6 3

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) GULSEPPE | | FIRST MIDDLE LAST TRIBUNNA | | 2a. DATE OF DEATH MONTH DAY YEAR 05 03 82 | | 2b. HOUR 9:00 P.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 03 29 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) METAL SCISSOR | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST NICK TRIBUNNA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA D'USLISE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 212-36-2655 | | 17. INFORMANT ADDRESS Mrs. Bambina Tribuna, 3500 Gough | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) progressive liver failure & progressive cirrhosis (c) multiple myeloma | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 3, 1982 to May 3, 1982 , that (I) (we) last saw the deceased alive on May 3, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Linda J. Rever, MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA J. REVER, MD. | | 22e. ADDRESS 22 S. GREENE ST. BALTO. MD. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-7-82 | | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling St. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natten | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Joseph . Manning, 2537, Oaklawn Cemetery, Baltimore, Md.

5-7-85

Funeral

Joseph . Manning, 2537, Oaklawn Cemetery, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ROSE | | TRIMBLE | | MAY 16, 1982 | | 1:55p _M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Female | Cauc. | Jan. 6, 1911 | | 71 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Austria | USA | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | JOHNS HOPKINS HOSPITAL | | Seamstress | | Slip Covers | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | | |
| Md. | --- | Baltimore | | Baltimore, Md. 201 N. Broadway, 21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Rudolph Franz | | Rose unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 214-20-7046 | | Walter F. Volkman, Balto, MD 21231 2233 Eastern Ave, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> (c) <u>diabetes, high blood pressure, leg ulcers.</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/11</u> 19 <u>82</u> , to <u>5/16</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>5/16</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| <u>Stenwaldt, M.D.</u> | | | | <u>5/16/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| <u>B. Herwaldt</u> | | <u>Johns Hopkins.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Direct Cremation | | 5/21/82 | | Greenmount Crematory | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Schimunek Funeral Home | | 3331 Brehms Lane, Balto, MD 21213 | | MAY 21 1982 | | <u>[Signature]</u> | |

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

1200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 6 6 5 | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---------------|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Ernest | | | MIDDLE E. | | | LAST Trinks | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 30 82 | | | 2b. HOUR 507 P.M. | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR 2 7 91 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | 8. IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production | | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mill | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 3316 Fleet St. 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Emil Trinks | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-5826 | | | 17. INFORMANT ADDRESS Mr. Erwin Trinks 114 N. Highland Ave. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 0389 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable sepsis, renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>L. hip fracture, ASCVD, Atrial fibrillation</u> Accident | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 11 P.M. 5 22 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Subject Fell | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3316 Fleet St. BALTO MD. | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) lost saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE C. Krause MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 5/30/82 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. KRAUSE | | | | | | 22e. ADDRESS BALTO. CITY HOSPITAL | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE June 3 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1982 | | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs after 24 hours, the certificate must be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|---|---|--|--|--|------------------------------------|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | YEAR | | 2b. HOUR | | PM | |
| WILHELMINA T. TROTTA | | | | 5-3-82 | | 5 | | 3 | | 11 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS. | | | |
| Female | White | Oct. 2 1915 | | 66 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Italy | U.S.A. | | | BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | | Homemaker | | - | | | | | |
| 13a. STATE | | | | | | | | | | | |
| Md. | | | | | | | | | | | |
| 13b. COUNTY | | | | | | | | | | | |
| - | | | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS | | | | | | | | | | | |
| 3519 Royston Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Luigi DiNenna | | | | Rosina Marino | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| no | | | | 217-48-8322 | | | | Antonio Trotta (husband) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular asystole</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4100 | | | | | | | | | | 2 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>anterior wall myocardial infarction</u> | | | | | | | | | | 12 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic coronary artery disease</u> | | | | | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 5/3/82 | | | | cardiogenic shock | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> , 19 <u>82</u> , to <u>5/3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| P. Dubyoski | | | | MD | | | | 5/3/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| DUBYOSKI | | | | UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 5/7/82 | | Holy Redeemer | | Baltimore | | Md. | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | MAY 4 1982 | | James Van Natten | | | |

2745 BP

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the report.

2. The second part of the report is a detailed description of the methodology used in the study. It includes the data sources, the data collection methods, the data analysis methods, and the results of the analysis.

3. The third part of the report is a discussion of the results of the study. It includes the main findings, the conclusions, and the implications of the study.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the project.

5. The fifth part of the report is a list of references. It includes all the sources of information used in the study.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 6 6 7 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST CLARENCE TROXELL | | | | MONTH DAY YEAR 5-3-82 | | | |
| 3. SEX | | | | 2b. HOUR | | | |
| MALE | | | | 3:35 M | | | |
| 4. RACE | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| WHITE | | | | 72 YRS. | | | |
| 5. DATE OF BIRTH | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MONTH DAY YEAR 05 31 09 | | | | BALTIMORE CITY MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| MARYLAND | | | | SUPERVISOR | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| U.S.A. | | | | GLASS CO. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| BALTIMORE | | | | ST AGNES HOSPITAL | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | |
| MARYLAND | | | | BALTIMORE | | | |
| 13c. INSIDE CITY LIMITS? | | | | 13d. STREET ADDRESS | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 1227 OAKLAND TERRACE ROAD | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST ROBERT LEE TROXELL | | | | FIRST MIDDLE LAST GERTRUDE A. MOSER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| NO | | | | 213-01-2576 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| RUTH E. CLUSTER | | | | 111 CREST AVENUE 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | |
| 5715 DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC ENCEPHALOPATHY | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF THE LIVER | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC RENAL FAILURE | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | | | | |
| 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (This hospital) attended the deceased from 5-3-1982 to 5-3-1982 , that (we) last saw the deceased alive on 5-3-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| Hubbard Raja MD | | | | 5/3/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| CITETITA RAJA | | | | 900 CATON AVE BALTIMORE MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| BURIAL | | | | 05-06-82 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| WOODLAWN CEMETERY | | | | WOODLAWN BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | MAY 5 1982 | | | |

BALTIMORE CITY

NEW YORK

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 2 6 6 8

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nellie M. Trunka</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5/3/82</i> | | 2b. HOUR <i>2:45 PM</i> | | | | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 30 14</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>108 S. Fayley St.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Edgar Kayler</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Leatrice Clark</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO IF UNKNOWN) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>234-22-1362 1</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> , 19 <i>82</i> , to <i>5/3</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>5/3</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>John Margolis MD</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>5/3/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John MARGOLIS</i> | | | | | | 22e. ADDRESS <i>Mercy Hospital, Balto, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | | 23b. DATE <i>May 6 82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Samuel Hunt-Dons</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i> | | 23e. DATE REC'D BY REGISTRAR <i>MAY 4 1982</i> | | |
| 24. FUNERAL DIRECTOR (NAME) <i>Cornelley Sons</i> | | | | | | | | | | 25. REGISTRAR'S SIGNATURE <i>Charles J. Nathan</i> | |

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections or paragraphs, with some lines being underlined. There are two circular punch holes visible on the right side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Department of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- STATE REGISTRAR | | JOHN LEE TURNER | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 6 6 9 | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST JOHN L TURNER | | 2a. DATE OF DEATH MONTH DAY YEAR 05-24-82 | | 2b. HOUR 12:55 A M | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 10 - 11 - 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - MAINTAINANCE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN PERRY HALL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS GREENHOUSE 11229 LILAC LANE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HOWARD LEO TURNER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA FOY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-03-1759 | | 17. INFORMANT ADDRESS MEHM T. THAUNG 6003 SAMARITAN HOSP. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA OF THE URINARY BLADDER 1889 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 05-22-1982 to 05-24-1982, that (we) lost saw the deceased alive on 05-24-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Mehm Themi Thaug | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 05-24-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHM T. THAUNG | | | | 22e. ADDRESS 3601 LOCH RAVEN BLVD. 6003 SAMARITAN HOSP. BALTO. MD 21239. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S LUTH. PERRY HALL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR John Ford | | | | ADDRESS 1211 Chesapeake Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Thayer | |

0001 20

RECEIVED

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL A. TURNER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 31, 1982 | | 2b. HOUR 06:50AM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 6 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | | | | 13b. CITY OR TOWN Baltimore | | 13c. STREET ADDRESS 9615 Orpin Road Randallstown, Maryland 21133 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No | | | | 16b. SOCIAL SECURITY NO. 219-05-9899A | | 17. INFORMANT Randallstown, Maryland 21133 Mrs. Celestine C. Reid 9615 Orpin Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperventilation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Increased Intracranial Pressure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Adenocarcinoma of Lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 months 3 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Compression of Trachea by Metastatic Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>December</u> , 19 <u>81</u> , to <u>May 31</u> , 19 <u>82</u> , that (I) lost lost saw the deceased alive on <u>May 30</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>B. Weiner</u> | | | | DEGREE MD | | | | 22c. DATE SIGNED 5/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN WEINER | | | | 22e. ADDRESS Johns Hopkins Hosp Balt MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel County, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Herbert E. Nutter Funeral Home 3035 W. NORTH AVE. | | | | ADDRESS BALTIMORE MARYLAND 21216 | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to perform an autopsy.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|---|---------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 2 6 7 1 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ollie TURNER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR may 28, 1982 | | 2b. HOUR 8:04 ^a M | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9/20/15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY City | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3809 Pall Mall Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Parker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Newman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Doris Woodard 3809 Pall Mall Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF Bigeminy alternating with normal sinus rhythm 15 hrs. (c) DUE TO, OR AS A CONSEQUENCE OF Status Post diuresis for acute pulmonary edema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: History of anteroinferior myocardial infarction, congestive heart failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that X (this hospital) attended the deceased from May 27, 1982, to May 28, 1982, that X (we) lost saw the deceased alive above X (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael A Hyle M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Hyle, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Pl. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1987 REGISTRAR'S SIGNATURE Renee Jan. [Signature] | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 6 7 2 | |
|--|--|--------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD TURPIN | | | | | | | | | | 2b. HOUR | |
| 3. SEX Male | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 8 13 59 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 22 | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 5-30-82 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1818 W. Lanvale Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abraham Turpin | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Russell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Elizabeth Davis 1818 W. Lanvale St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 2:26 AM 5-30-82 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot during altercation | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 900 blk. Calhoun Street Balto., Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margareta A. Koroll</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 5-30-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margareta A. Koroll, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | | |



RECEIVED

POST OFFICE

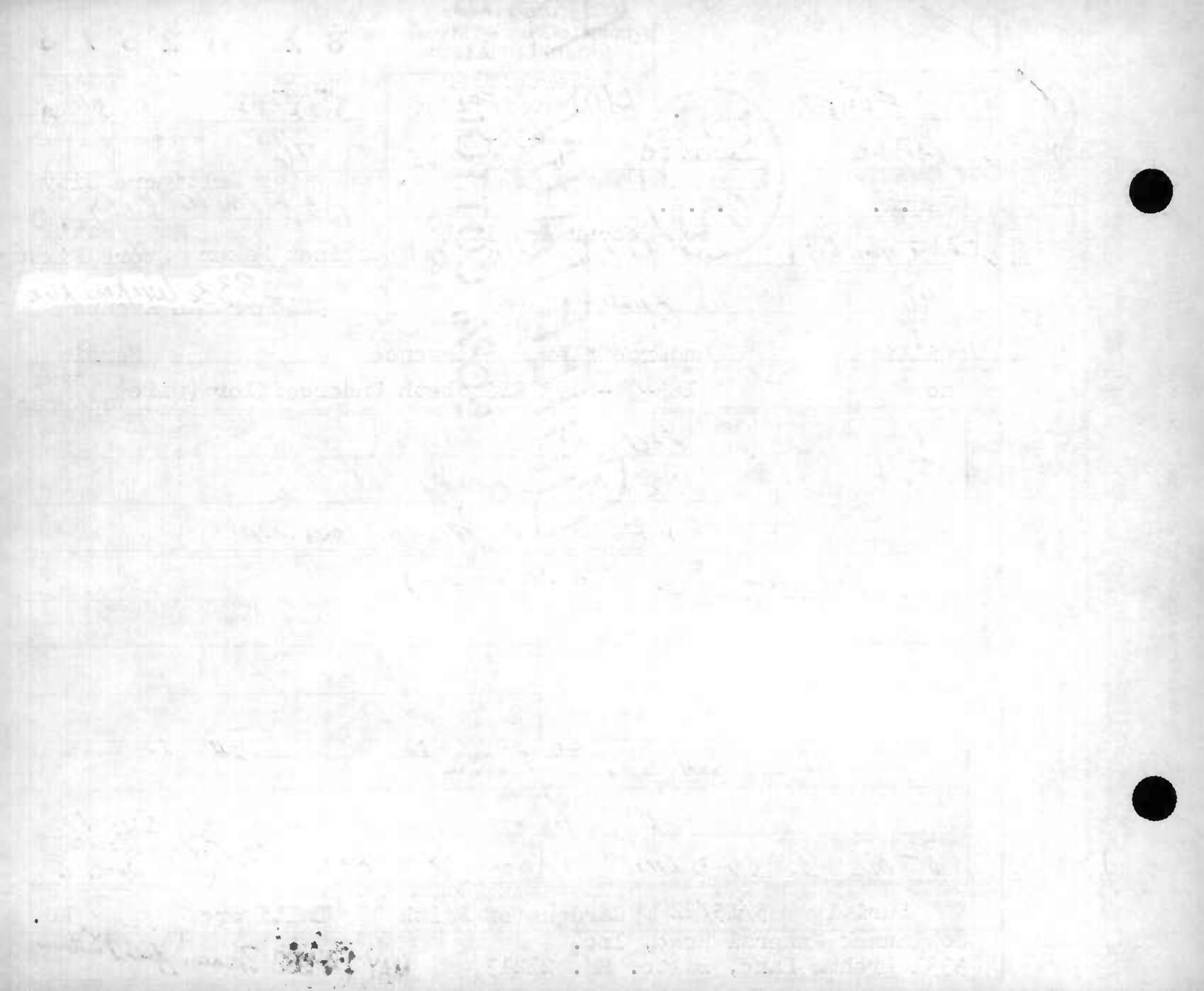
CHAS. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 2 6 7 3 REG. NO. | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elmer Undercoffler ELMER N. UNDERCOFFLER | | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-82 5-12-82 | | 2b. HOUR 5:15 AM | |
| 3. SEX Male MALE | 4. RACE White White | 5. DATE OF BIRTH MONTH DAY YEAR 6-30-05 6 30 05 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY Baltimore City BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN BALTIMORE CITY) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker | | 12b. KIND OF BUSINESS OR INDUSTRY Store Fixtures |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD- | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3448 Erdman Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Undercoffler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Ferris | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. 184-01-8693 | | 17. INFORMANT ADDRESS Elizabeth Undercoffler (wife) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4280 DUE TO, OR AS A CONSEQUENCE OF (b) COPD SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) C.H.F. and Arrhythmia; ANEMIA. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) POSSIBLE E.C. malignancy | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-21-82 to 5-11-82 , that (I) (we) lost saw the deceased alive on 5-11-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A. Sidhu | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJMA S. SIDHU | | 22e. ADDRESS 2216 Lyndon Gate Rd. Columbia Md. 21044 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 24. FUNERAL HOME (NAME AND ADDRESS) Schimmek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE May 14 1982 | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|------------------|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Updegraff | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 5 31 19 82 | | | 2b. HOUR 8:30 P.M. | |
| 3. SEX M | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12-24-1911 | 6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 5 31 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Ind. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Laundry Manager | | 12b. KIND OF BUSINESS INDUSTRY Hospital |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Ind. | | 13b. COUNTY Ind. | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1503 McHenry St. 21223 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Updegraff | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Burkhardt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.W.T. 26-03-5499 | | 17. INFORMANT Dorlene Jacarinas | | ADDRESS 1503 McHenry St. 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 6-1-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | ADDRESS 111 Penn Street | | | | | |

| | | | |
|---|-----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Burial | 23b. DATE 6-4-1982 | 23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundee Co. Ind. |
| 24. FUNERAL DIRECTOR NAME John J. Cronan | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1982 | |
| 25b. REGISTRAR'S SIGNATURE Name J. Cronan | | | |

10051 20

THE UNIVERSITY OF CHICAGO

CHICAGO
LIBRARY



THE UNIVERSITY OF CHICAGO
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|---|--|---------------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | 8 2 1 2 6 7 5 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| MARIE A. UTERMÖHLE | | | | | 5-22-82 | | | | |
| SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | white | | 12-31-93 | | 88 | | 12:35 A.M. | |
| BIRTHPLACE (CITY OR COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore, Maryland | | USA | | | | Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Mercy Hospital | | | | Homemaker | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Baltimore | | Baltimore | | | | Belvedere Hotel 1 E. CHASE ST. Apts. | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| John J. WARD, Sr. | | | | | Elizabeth E. Fitzpatrick | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT'S NAME AND ADDRESS | | |
| NO | | | | | yes - ? | | Mrs. Regina Nicholson 231 Commons Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Adult respiratory distress syndrome | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Sepsis, DIC | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that this hospital attended the deceased from 3/12, 1982, to 5/22, 1982, that (I) (we) lost | | | | | | | | | |
| saw the deceased alive on 5/22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| Edward C. Watters III | | | | | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Edward C. Watters III | | | | | Mercy Hospital Baltimore Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN) | | | |
| BURIAL | | 5/24/82 | | New Catholic Cem. | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE | | 25b. REGISTRATION NO. & SIGNATURE | | | | | |
| 736 Edmondson Ave. Catonsville, Md. 21228 | | MAY 24 1982 | | | | | | | |

X

AGU



15 MAY 1974

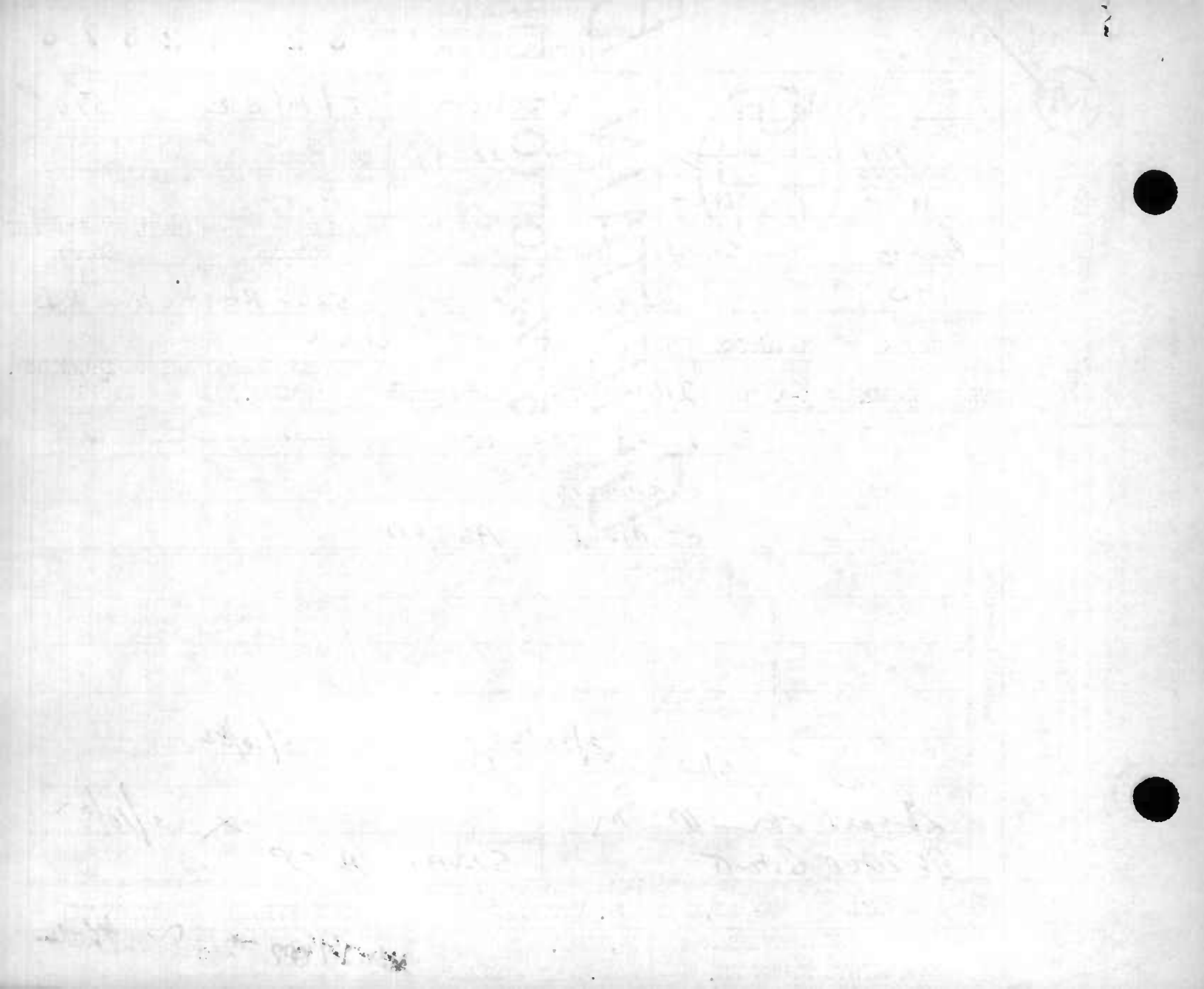
2,000 W 112
112 014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 6 7 6 | | | |
|---|--|--|--|--|--|---|--|--|--|--|-----|--------|----------|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Wilfred | | Vachon | | | | | | 5/10/82 | | | | | 5:10 PM |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | |
| MALE | | CAUCASIAN | | MONTH 09 DAY 22 YEAR 77 | | 84 | | YRS. | | MONTHS | | DAYS | |
| 9. BIRTHPLACE (CITY, STATE, COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| CONNECTICUT | | USA | | | | CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. DRIVER'S LICENSATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. RAILWAY EXPRESS INDUSTRY | | | | | | | |
| Baltimore | | SINAI HOSPITAL | | DRIVER | | RAILWAY EXPRESS | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 2nd FL. | | #21215 | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5300 Reisterstown RD | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | |
| GEORGE | | XXXXXX VACHON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| YES XXXX WWI-ARMY | | 216030787 | | HONEY FLAKS | | 5300 REISTERSTOWN RD. | | | | | | | |
| | | | | BALTO., MD | | 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) LIVER FAILURE | | | | | | | | | | | | | |
| 5715 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | |
| (b) CIRRHOSIS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) GI bleed, ASCVD | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/26/82, 19, to 5/10/82, 19, that (I) (we) lost saw the deceased alive on 5/10, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| Gerald Gant | | | | M | | | | 5/10/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| GERALD GANT | | | | SINAI HOSP | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | | |
| BURIAL | | | | MAY 12, 1982 | | MD. VETERANS | | CROWNSVILLE | | MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SOL LEVINSON & BROS., INC. | | | | MAY 17 1982 | | | | D. J. Parker | | | | | |
| 6010 REISTERSTOWN RD. | | | | BALTO., MD | | | | 21215 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 6 7 7 REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Pompeo | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 2, 1982 | | | |
| 3 SEX Male | | | | 2b. HOUR 5 A M | | | |
| 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR May 22, 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3600 Claremount Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergy-Priest | | 12b. KIND OF BUSINESS OR INDUSTRY R. Catholic | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3600 Claremount Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unk Vadacca | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 218-64-4140 | | 17 INFORMANT ADDRESS Rev. Robert Pett, C.M. 3600 Claremount | |
| 18 CAUSE OF DEATH Enter only one cause per line for part 1, and as many as needed for part 2. | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Systemic heart disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Persistent vascular disease | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 75 to May 1 19 82 , that (I) (we) lost the deceased alive on May 1 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-4-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.E. WALSH MD | | | | 22e. ADDRESS 333 ST. PAUL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 5, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph N. Zannino Fun., 263 S. Conkling St. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 6 7 8 | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TERESA Annette VALENTINE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1982 | | 2b. HOUR 4:35AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 15, 1959- | | 6. AGE (IN YEARS LAST BIRTHDAY) 22 | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. Store | | 12b. KIND OF BUSINESS OR INDUSTRY Manager | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6921 Chambers Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas P Valentine | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Burkett | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-80-3749 | | 17. INFORMANT ADDRESS Thomas P. Valentine 6921 Chambers Rd | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS, CEREBRAL EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>FULMINANT HEPATITIS</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>82</u> , to <u>0435 5/14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>0435 5/14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Keith J. Sivertson</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/14 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIVERTSON | | 22e. ADDRESS JOHNS HOPKINS HOSP., BALT., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore. | | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | REGISTRAR James J. [Signature] | | | | | |

James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 7 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THEODORE VICTOR | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 06 82 | | 2b. HOUR 4:00 A.M. |
| 3. SEX MALE | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 12 10 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILIPPINES | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steward | | 12b. KIND OF BUSINESS OR INDUSTRY shipping |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Arbutus | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 5505 Osage Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ADDRESS Mrs. Caroline W. Victor 5505 Osage Avenue | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE 27 DAYS |
|--|--|---|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, DIABETIC GANGRENE | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/3/82 , 19____, to 5/1/82 , 19____, that (I) (we) last saw the deceased alive on 5/1/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | 22c. DATE SIGNED 5/1/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTASIO R. DE CASTRO | | 22e. ADDRESS ST AGNES HOSPITAL | |

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5/4/82 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home | | ADDRESS 1328 Sulphur Spring Rd. | 25a. DATE REC'D. BY REGISTRAR MAY 3 1982 |

CRPT E YASS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

| Items 18b. Film#G568 | | | | STATE OF MARYLAND | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 5 8 0 | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR 6-4-82 AL | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES | | | | FIRST Wade | | | | 2a. DATE OF DEATH MONTH 5 DAY 8 YEAR 82 | | | | 2b. HOUR 6:10 AM | | | |
| 3 SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 7 DAY 18 YEAR 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp. of Md. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2923 Violet Avenue 21215 | | | | | | | |
| 14 FATHER'S NAME FIRST James MIDDLE LAST Wade | | | | 15. MOTHER'S MAIDEN NAME FIRST Violet MIDDLE Scott LAST H | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 228 16 7616 | | 17. INFORMANT DIANA WADE | | | | ADDRESS 2923 Violet Ave | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis with Corresponding Shock | | | | | | | | | | | | | | | |
| 5609 DUE TO, OR AS A CONSEQUENCE OF (b) INTRA Abdominal Catastrophic Process | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. breakdown anastomotic sites | | | | | | | | | | | | | | | |
| (c) multiple intraabdominal abscesses and fistulae | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 3/25/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction & Perforation | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 3/22 , 19 82 , to 5/8 , 19 82 , that (b) (we) lost saw the deceased alive on 5/8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Jeffrey Chircus MD | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/8/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey H. Chircus MD. | | | | 22e. ADDRESS Sinai Hospital of Baltimore | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 5-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY MT Auburn Cem | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE MD | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME BROWN-Thompson F.H. | | | | ADDRESS 1913 W. BA/Ho | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE Francis Van Natten | | | | | | | |



CONFIDENTIAL
IA 58-1-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 2 6 8 1 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIR ANNA MIDDLE ANNA | | LAST WAGNER WAGNER | | 2a. DATE OF DEATH MONTH MAY DAY 9 YEAR 82 | | 2b. HOUR 3:55 AM | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH 7 DAY 23 YEAR 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS 5 DAYS 9 HOURS 82 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) house-wife | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1519 Elrino Street | |
| 14. FATHER'S NAME FIRST ? MIDDLE ? LAST Zermerski | | 15. MOTHER'S MAIDEN NAME FIRST ? MIDDLE ? LAST unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. no | | 17. INFORMANT ADDRESS George Wagner 2826 Superior Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) VASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) no | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from APRIL 21, 19 82 , to MAY 9, 19 82 , that (I) (we) lost saw the deceased alive on MAY 9, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.L. BIJPURIA MD. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY St Stanislaus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR <i>Walter Orlewski</i> | | ADDRESS <i>1005 Dandell Avenue</i> | | | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

| NAME | ADDRESS | CITY | STATE | ZIP | DATE |
|----------------------|----------------------|----------------|-------|-------|---------|
| George Warner | 2020 Superior Avenue | Baltimore | MD | 21205 | 10/1/77 |
| Neimetski | ? | Baltimore | MD | 21205 | 10/1/77 |
| ? | ? | Baltimore | MD | 21205 | 10/1/77 |
| Church Home Hospital | house-wife | Baltimore | MD | 21205 | 10/1/77 |
| USA | ? | Baltimore City | MD | 21205 | 10/1/77 |

Bureau of Census Statistics
U.S. Department of Commerce
Washington, D.C.

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 8 2

REG. NO.

| | | | | | |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 20. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 20. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | M | |
| Frances L Wagner | | 5 19 82 | | 13 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. YRS. | |
| F | C | Nov 22 1908 | 73 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| November 1, 1908 | U.S.A. | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Maryland, Balto. | 3939 Roland Ave Apt 911 | | Receptionist | | Dental |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | - | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3939 Roland Avenue | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | |
| William E. Wagner | Ella May | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (YES, NO OR (UNKNOWN) (GIVE DATES)) | | |
| 17. INFORMANT | | 18. SOCIAL SECURITY NO. | | | |
| Dr. Richard G. Simmonds | | 212 07 1352 | | | |
| ADDRESS | | 300 / Dean Drive Rockville Md 20851 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY | | 20c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY | | 21c. LOCATION | |
| AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (the hospital) attended the deceased from 1959 to May 19 82 and that (b) (the deceased) saw the deceased alive on Feb 2 82 and that in (my) opinion death occurred on the date and hour and from the causes stated | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| Dr. William G. Helfrich, MD | | 5006 Roland Avenue | | 5/20/82 | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | May 22, 1982 | | Louden Park | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Burgee Funeral HOME Baltimore, Maryland | | MAY 26 1982 | | Thane Jan... | |

October 1, 1961

101 111 1000 1111

11-11-66

analysis, synthesis, and program design

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 8 3

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 2a DATE OF DEATH | | 2b HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 2b HOUR | |
| FIRST MIDDLE LAST | | 5 22 82 | | 10 35 AM | |
| 2 SEX | | 3 RACE | | 4 DATE OF BIRTH | |
| FEMALE | | WHITE | | MONTH DAY YEAR | |
| | | | | 06 23 30 | |
| 5 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | |
| Maryland | | 51 YRS | | MONTHS DAYS HOURS MIN. | |
| 8 CITY OR TOWN OF DEATH | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 10 IF UNDER 24 HRS | |
| Baltimore | | Baltimore City MD. | | HOURS MIN. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore City Hospital | | Cafeteria Worker | | Board of Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | |
| 13a. STATE COUNTY | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1910 Codd Avenue | |
| Maryland Baltimore | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Francis A. Kreiner, Sr. | | Helen A. Conniff | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 218-26-7369 | | A-432 Oriole Avenue Balto., MD. 21224 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY | | | | | |
| IMMEDIATE CAUSE (a) 5739 Cardiopulmonary arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Gastroesophageal bleeding | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) Severe liver disease | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Lucien Levy | | | | 5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Lucien LEVY | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/25/1982 | | Holly Hill | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| CITY OR TOWN COUNTY STATE | | | | | |
| White Marsh Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME Duda-Ruck, Inc. | | | | | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | MAY 24 1982 | | James Van Natta | |

100-100000

7 02 01 10

WAGNER RUTH

WHITE 02 00 01

000000

100-100000

100-100000

100-100000

100-100000

4 1976821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 6 8 4 REG. NO. | | |
|--|--|--|--|---|--|---|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACQUELINE E WAHL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 16, 1982 | | | 2b. HOUR 5:25pm | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8104 Cambridge Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Remie Surprenant | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Louise Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 043-14-3326 | | 17. INFORMANT ADDRESS Capt. Walter H. Wahl, 8104 Cambridge Drive, Frederick, Md. 21701 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Rectal Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1541 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/6/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SBO | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 82 to 5/16 19 82 , that (I) (we) lost saw the deceased alive on 5/16 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE M. D. | | | | DEGREE | | | | 22c. DATE SIGNED 5/16 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marc Nelson | | | | 22e. ADDRESS John Hopkins | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial Gardens | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Md. | | | | |
| 24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

15 Bd 171

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 6 | 8 | 5 |
|--|--|--|--|--|--|---|--|--|--------------------------------|--|------------------------------|---|---|--------------------------|---|---|
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Edith MIDDLE Mildred LAST WAIN EDITA WAIN | | | | | | | | | | 2a. DATE OF DEATH MONTH 5 DAY 11 YEAR 82 | | | | 2b. HOUR 11:15a M | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH April 11, 1903 4 11 3 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRN HOURS MIN | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY) Sinai Hospital | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife | | 12b KIND OF BUSINESS OR INDUSTRY Home | | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b COUNTY Queen Anne's | | 13c. Chester | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS R.D. #1, Box 478A ROUTE 1 Box 478A | | | | | | | | |
| 14 FATHER'S NAME FIRST Kirby MIDDLE Lawson LAST Smith | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ellen LAST Majors | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 218-05-1152 | | 17 INFORMANT Son ADDRESS 7000 Alden Road Edwin V. Thomas, Baltimore, Md. 21208 | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Bernard F. Hozelousky | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> NURSE STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/11/82 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD F. HOZELOUSKY | | 22e. ADDRESS C/O SINAI HOSPITAL, BALTO., MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Chesterfield | | 23d LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md. | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME James H. Barton, Jr., | | ADDRESS Barton Bros. | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 2 6 8 6
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Marvin V. Walker | | | 2a. DATE OF DEATH MONTH DAY YEAR May 27, 1982 | | 2b. HOUR M M |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7 24 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1709 1/2 Patterson Park Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Moore | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Osie V. Walker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-03-8796 | | 17. INFORMANT ADDRESS Martha Bookman 1709 1/2 Patterson Pk. Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 Metastatic lung cancer IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ Angina Pectoris | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from July 1980 , 19 82 , to May 27 , 19 82 , that (1) (we) last saw the deceased alive on May 12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kendall R Faulkner MD | | DEGREE | | 22c. DATE SIGNED 5/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENDALL R FAULKNER | | 22e. ADDRESS Geriatric Out-patient Md General Hospital / Balto Md 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | |
| 25b. REGISTRAR'S SIGNATURE James Van Houten | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV

8

10

12

14

16

18

20

22

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|----------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 2 6 8 7 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| Mary Lillian B. Walker | | | | | 5 13, 82 7:15 A | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | Black | | 2 14 1894 | | 88 YRS | | IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | | | Baltimore City, Maryland MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 2030 N. Fulton Avenue | | | | Cook | | Pvt. Family | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | 2030 N. Fulton Ave. Baltimore, Maryland 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| William Gray | | | | Aletha Egans | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 220-42-9077 | | Baltimore, Md. 21207 circle Mrs. Hortense Franklin 3803 Coronado | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Sen. l. ty - arteriosclerosis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>My pertension</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>4019</u> | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-8-82</u> , 19 <u>82</u> , to <u>3-9</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3-9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE <u>Dr.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| <u>Dr. Harry Wasserman</u> | | | | | | | | <u>5-17-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Dr. Harry Wasserman | | | | MD 3701 Clarks Lane, Baltimore, Md. 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 5/18/82 | | Arbutus Mem. Park | | Baltimore County, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HERBERT R. VENTER FUNERAL HOME 3035 N. NORTH AVE. BALTIMORE, MARYLAND 21216 | | | | MAY 18 1982 | | <u>James J. Nathan</u> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12688 | | | | | |
|--|--|------------------|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON E. WALKER | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 9 19 82 | | 2b. HOUR 8:40 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 3 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 27 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 9 19 82 | | 7d. HOUR p M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 N. Aisquith St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1328 N. Chester Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Walker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mina Conway | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | | | 17. INFORMANT ADDRESS Mina & Andrew Walker 1328 N. Chester St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest & abdomen (handgun)</u> 9650 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-9- 19 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 200 N. Aisquith St., Balto. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-10-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | | | | 25b. REGISTRAR'S SIGNATURE <i>Francis J. [Signature]</i> | |

100% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | 8 2 1 2 6 8 9 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) First (Saint) Middle Frank J. Last Walker (Saint James) | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 4 82 | | 2b. HOUR 730 A M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 26 37 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U of MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2445 Callow Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Walker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betha Watkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 231429046 | | 17. INFORMANT ADDRESS Calvin Brown 2833 Hillen Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 A acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4/82 to 5/4/82 19____, that (I) (we) lost saw the deceased alive on 5/4/82 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. David Matchar | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID MATCHAR | | | | 22e. ADDRESS 22 S. Greene St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Broadneck Va. | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE Francis J. Watkins | | | |

W.C. Church, 1101 E. North Ave.
May 1, 1903
Baltimore, Md.



Johns Hopkins

U. of M.D.

Boston

M.D.

Baltimore

W. A.

W. A.

Black

M.D.

Black

Black

(1903) (1903)

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------------|---|--|
| 8 2 1 2 6 9 0 CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| BERTHA WALLMAN | | | | | MAY 18, 1982 | | | 2:30PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| FEMALE | | WHITE | | SEPT. 1895 | | 86 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| RUSSIA | | USA | | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | 3601 FORDS LA., APT. 503 | | | | HOUSEWIFE | | AT HOME | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| UNKNOWN | | | | | UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | | | | 098-22-4561 | | MR. JACK WADDEMAN | | | |
| | | | | | 8401 DOWNEY DALE DR. RANDALLSTOWN, MD 21133 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MI | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HASCD | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 6, 1978, to MAY 18, 1982, that X (we) last saw the deceased alive on 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Dr. Arthur H. Larson | | | | | | | 5/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | |
| Dr. Arthur H. Larson | | | 3640 FORMS LANE BALTO MD 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | | MAY 20, 1982 | | WORKMEN CIRCLE | | BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | MAY 25 1982 | | [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

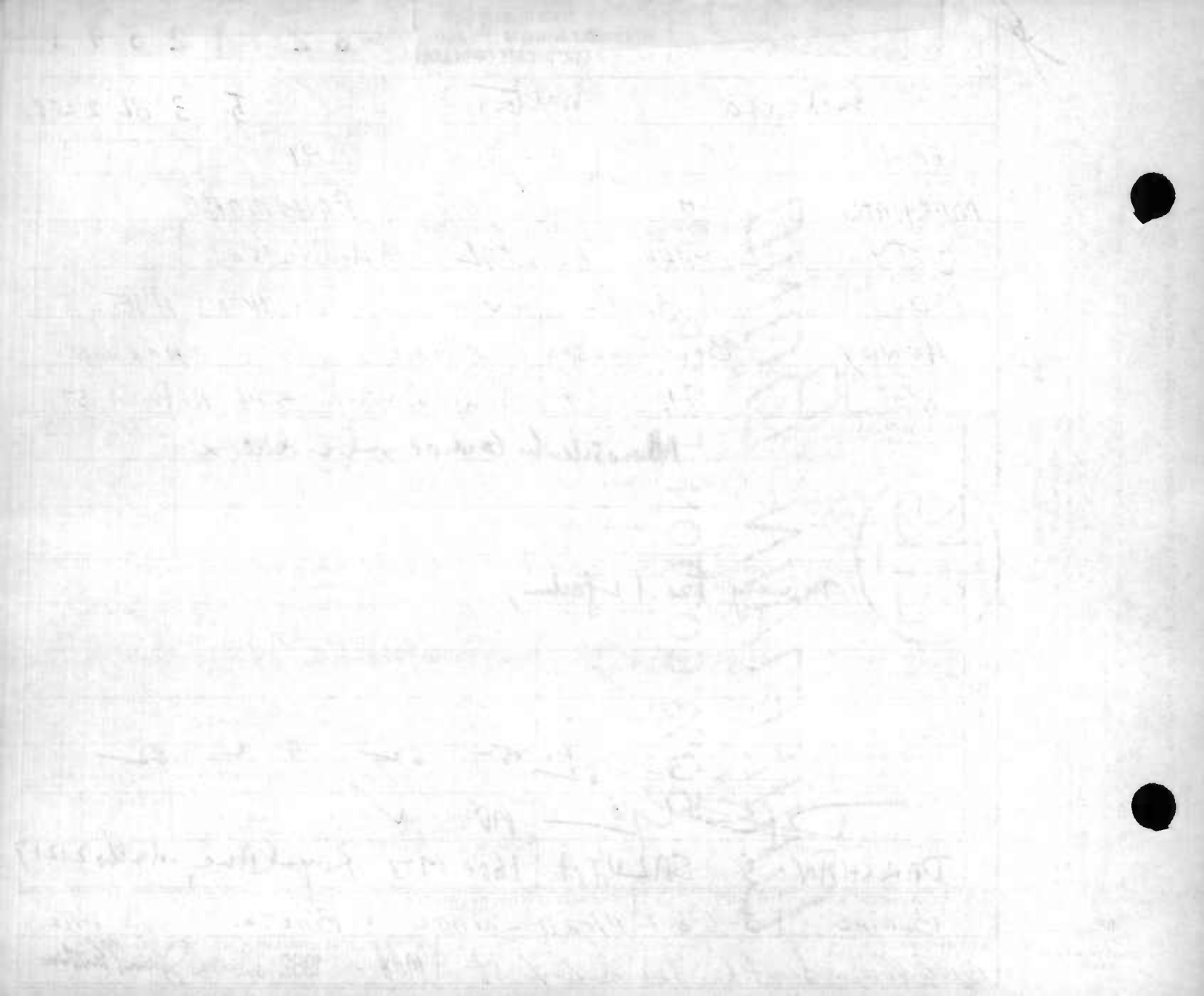
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 1

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Fredricka Walters | | 2a. DATE OF DEATH MONTH 5 DAY 03 YEAR 82 | | 2b. HOUR 2:25 PM | |
| 3. SEX FEMALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH 2 DAY 04 YEAR 91 | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD. | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | |
| 14. FATHER'S NAME FIRST HENRY MIDDLE BEUENRUGEN LAST HERMAN | | 15. MOTHER'S MAIDEN NAME FIRST MINNIE MIDDLE HERMAN LAST HERMAN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-58-9640 | | 17. INFORMANT JOHN WALTER ADDRESS 324 N. PACA ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Minors Trauma | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-25-1982 to 5-3-1982 that (I) (we) lost saw the deceased alive on 5-3-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D. Saluja MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA | | 22e. ADDRESS 1600 M-T Royal Ave, Balto 21217 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE | |
| 23d. LOCATION CITY OR TOWN BALTO. COUNTY STATE MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Dick Hoenes Sons F.A. ADDRESS 322 S. High St | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1982 25b. REGISTRAR'S SIGNATURE Frances Van Thullen | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVIN G. WARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 82 | | 2b. HOUR 3⁴⁰ A M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Delivery Man | | 12b. KIND OF BUSINESS OR INDUSTRY Milk Dairy | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Middle River | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 4040 Chestnut Rd. 21220 | | 14. FATHER'S NAME FIRST MIDDLE LAST Robert Ward | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gollery | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212 09 5945 | | 17. INFORMANT NAME ADDRESS Margaret M. Ward Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contingent arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of upper esophagus, hypertrophy, and larynx DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. about one year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION 4/12/82 5/3/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of upper esophagus, hypertrophy, and larynx | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 10, 1982 to May 22, 1982 , that (I) (we) last saw the deceased alive on May 21, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dale M. Meyers, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALE M. MEYERS M.D. | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Bruzdinski Funeral Home PA 1407 Old Eastern Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1500

1500

WARD

1500

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

1500

1500

1500

1500

1500

DATE N. PETERS N.O.

1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 3
REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Carl W. Ward | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 82 | | 2b. HOUR 4:15 A.M. | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 8 29 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE md. | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1933 Eastern Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HURLEY WARD | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Victoria MARTIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 230185381 | | 17. INFORMANT (SISTER) ADDRESS MARY MOORE Peguason, VA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 3030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peritonitis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 16 19 82 , to May 22 19 82 , that (I) (we) lost saw the deceased alive on May 21 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert Mich | | DEGREE | | 22c. DATE SIGNED 5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert MICH | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | 23b. DATE 5-25-1982 | | 23c. NAME OF CEMETERY OR CREMATORY PARK LAWN | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hampton Warwick, VA | | | | | |
| 24. FUNERAL DIRECTOR NAME Fleming Funeral Service Benson | | ADDRESS Baltimore | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST CLARENCE L. WARE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-30-82 | | | 2b. HOUR 11pm | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 14 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH S. BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South BALT. Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Welder | |
| 13a. STATE MD | | 13b. CITY OR TOWN PASADENA | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 1209 Meadow Rd | | 13e. ZIP CODE 21122 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William WARE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Rowe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 231-09-9639 | | 17. INFORMANT NAME ADDRESS CHART Margaret L. Ware Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESTRICT HYPOTENSION 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): BRONCHOGENIC CARCINOMA | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR - | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) - | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) - | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE - | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 23 19 82 , to May 30 19 82 , that (I) (we) lost saw the deceased alive on May 30 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Herbert Juarez | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT JUAREZ | | | | 22e. ADDRESS South Baltimore General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE June 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnee, A.A. Co. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCutty Funeral Home, Mt. & Ticken Rd. Pasadena Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | | | | |

BP.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 5

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CORA Stevenson WASHINGTON | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1982 | | | 2b. HOUR 6:05PM | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 28 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2215 Belair Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Zack Stevenson | | | | 15. MOTHER'S MAIDEN NAME MIDDLE Minnie Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 216-14-0256 | | 17. INFORMANT ADDRESS Thurman Washington 2215 Belair Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1548 DUE TO, OR AS A CONSEQUENCE OF (b) Supine Systemic Metastatic Carcinoma ~ 1yr DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 4/7, 3/11, 3/13 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cloacogenic Carcinoma | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 82 , to May 7 , 19 82 , that (I) (we) lost saw the deceased alive on May 7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Thomas F. Green M.D. | | | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Green M.D. | | | | | | 22e. ADDRESS Johns Hopkins Hosp. BALT. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. Morch F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE May 10 1982 Frances Jean Katten | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

C.F.C.S.

28



100-100000

100-100000

100-100000

100-100000

2/12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRÉSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12696

| | | | | | | | |
|--|------------------|--|---|---|------------------|---|---------------------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donell (Donald) Antonio Washington | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 15 1982 | | 2b. HOUR M 15 | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YRS. 5 24 59 | 6. AGE (IN YEARS) (BIRTHDAY) MONTHS DAYS HOURS MIN. 22 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 15 1982 | 7d. HOUR M 15 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alfred Washington | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Peay | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Bernice Washington 210 N. Dallas Ct. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> Weapon: <u>Unspecified</u> DUE TO, OR AS A CONSEQUENCE OF 9654 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50 P.M. 5/15 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street Front of | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 220 N. Caroline St., Baltimore City, MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Virginia L. Dolan MD</u> TITLE (SPECIFY) <u>M.D. Assistant</u> MEDICAL EXAMINER DATE SIGNED <u>5/16/82</u> EXAMINER'S NAME (TYPE OR PRINT) ADDRESS <u>111 Penn Street, Baltimore, MD 21201</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | 25. DATE REC'D. BY REGISTRAR MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE <u>Rene J. [Signature]</u> | |

BP

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 7

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ARCHIE WATKINS | | 05 19 82 | | 11:30 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | 2 14 14 | 68 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | University Hospital | | Truck Driver | | A & P |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Edward Watkins | | Goldie Ramble | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| YES | | WW II | Anna Shadle 4129 Potter Street 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF ASCVD | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | 3/26 79 5/19 82 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/27 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Kuang-Yen Huang | | MD | | 5/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| KUANG-YEN HUANG | | 517 SCOTT ST BALTO MD 21223 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 5/22/82 | Loudon Park Cemetery | | Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | MAY 21 1982 | | | |

15281 8

NAVY

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

NAVY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 35.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 6 9 8

REG. NO.

| | | | | | | | | | | | |
|---|------------------------------|---|---|--|--------------------------------------|--|-----------------|--|------------------|----------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Doris | | A | | Watkins | 5 | | 3 | 14 | 1982 | 5:42 AM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | White | | 11 7 14 | | 67 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md | US | | | | City | | | | | | |
| 10. CITY OR TOWN OF DEATH | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Univ of Md | | | | Homemaker | | Home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md | | AA | | Sherwood Forest | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 909 Ravenshead Hill | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Emory Webster Morrison | | Rachel May Perry | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| NO | | 705-09-0501 | | Edgar R. Watkins | | | | | | | |
| | | | | 909 Ravenshead Hill | | | | | | | |
| | | | | Sherwood Forest, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia/sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 mos.</u> <u>20 years</u> | | | | | | | | | | | 1905 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Respiratory failure and intubation</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>82</u> , to <u>5/31</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Steven L. Joffe MD | | | | | | | | 5/31/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Steven L. Joffe | | Univ of Md Hosp. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | June 4, 1982 | | Ft. Lincoln | | Brentwood | | MD | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. BY REQUEST OF DECEASED OR NEXT OF KIN | | | | 25b. SIGNATURE | | | | | |
| John M. Taylor & Sons, Annapolis, MD | | | | | | | | | | | |

MEDICAL CERTIFICATION

93461-20170809

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 6 9 9

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|-------------------|--|--|--|------------------|--|---|--|-------|--|--|--|------|--|------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | XX MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| Gordon (Joseph) | | | | | | Watkins Jr | | 5 | | 31 | | 19 | | 82 | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| male | | black | | 4 22 1972 | | 10 YRS | | | | | | 5 | | 31 | | 19 | | 82 | | 7:10 P. M. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Md | | | | USA | | | | | | | | Baltimore City, MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | | Baltimore City Hospitals - DOA | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | | | |
| Md | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 5518 Sarril Road | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Gordon | | | | Watkins, Sr Barbara | | | | Shipley | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | ADDRESS | | | | | |
| No | | | | N/A | | | | Barbara Shipley | | | | | | | | 5518 Sarril Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) Drowning | | | | | | | | | | | | | | | | | | | | | |
| 7 9108 | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | 5:15 P.M. 5 31 19 82 | | | | subject drowned | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | |
| | | | | swimming pool | | | | 5500 Sarril Rd., Baltimore, Maryland | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | | |
| Virginia L. Dolan | | | | M.D. Assistant | | | | 6-1-82 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | |
| Burial | | | | 6/4/82 | | | | Eastview Mem Park | | | | Baltimore | | | | | | | | | |
| | | | | | | | | | | | | Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| William C. March | | | | F/H 1101 E. North Ave | | | | JUN 7 1982 | | | | Frances Jan Kestner | | | | | | | | | |

CONFIDENTIAL - SECURITY INFORMATION

100-100000-100000

[Faint, mostly illegible text covering the main body of the page, possibly bleed-through from the reverse side.]

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 7 0 0
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John D. Watkins | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-26-82 | | 2b. HOUR 10:40 PM |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10 19, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1508 Fleet Street |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Watkins, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 218-03-3366 | | 17. INFORMANT ADDRESS Paul Watkins 1027 Valley Street | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Chronic Renal Failure

5850
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

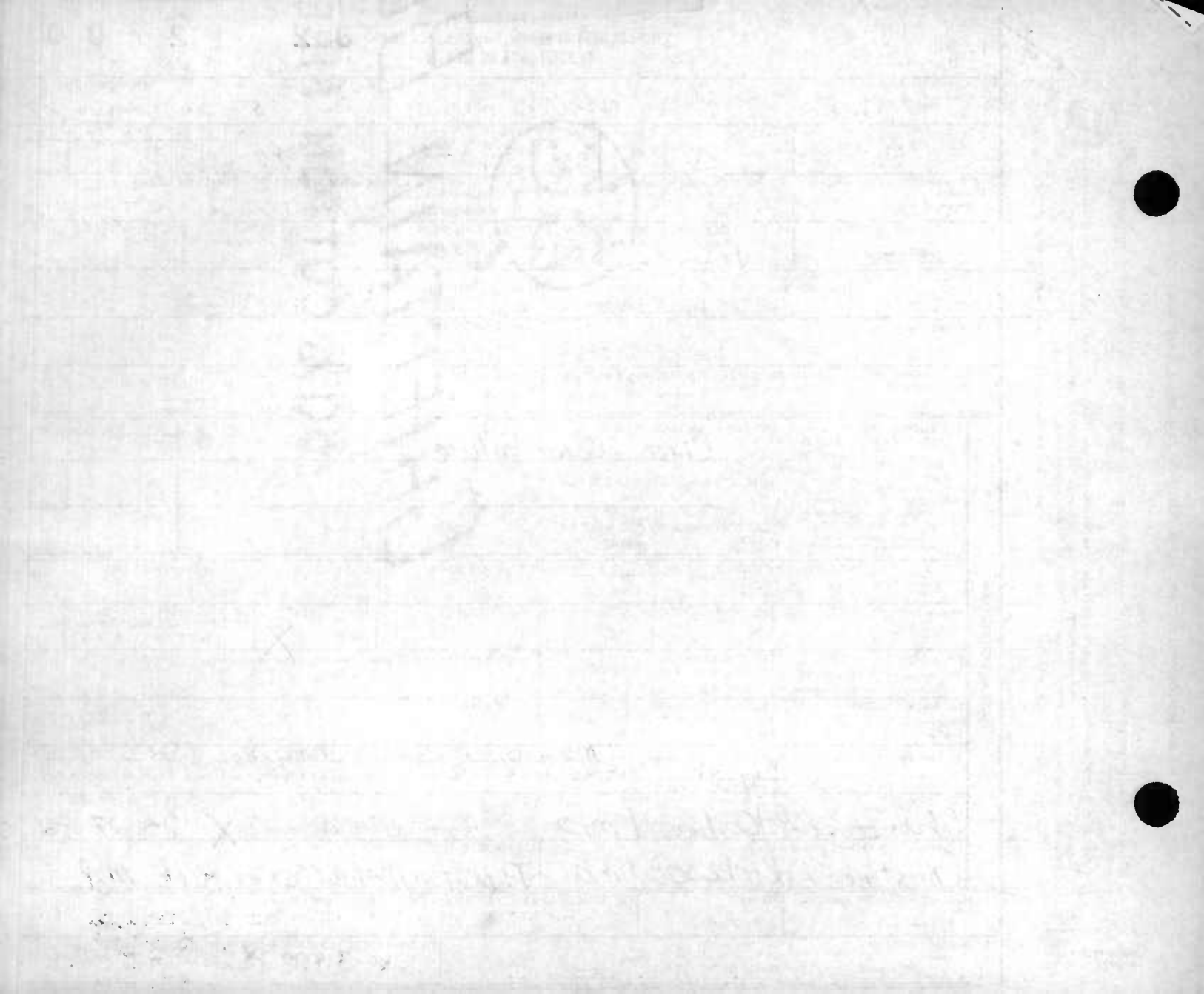
| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 10, 19 82, to May 26, 19 82, that (I) (we) last saw the deceased alive on May 26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Christine L. Kirkwood MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christine L. Kirkwood MD | | 22e. ADDRESS JL Deaton Medical Center, Balto, Md. | | | |

| | | | |
|---|---------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 6/1/82 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Maryland |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 3 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 2 7 0 1

FOR
1 - STATE
REGISTRAR

| | | | | |
|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) IDA WAXMAN | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 18 1982 | | 2b. HOUR 10:30 AM |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS |
| 7a. BIRTHPLACE (COUNTRY) POLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC CENTER + #237124 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 7109 BOXFORD RD., BALTIMORE 21225 |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-033857 | | 17. INFORMANT MRS. LILYON FRADIN 2903 TANEY RD. BALTO., MD 21209 |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ± 1 HR. |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from APRIL 26, 1982, to MAY 18, 1982, that (we) lost saw the deceased alive on MAY 18, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE Evelyn | | DEGREE | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELLITA O. KW | | 22e. ADDRESS LEVINDALE HEBREW GERIATRIC CENTER + HOSPITAL | | | |

| | | | |
|---|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE MAY 19, 1982 | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | 23d. LOCATION BALTIMORE COUNTY MARYLAND |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1982 | |

10/5/58

117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 0 2 | |
|--|---|---|---|--|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM W. WAYS | | | 2a. DATE OF DEATH MONTH 5 DAY 18 YEAR 82 | | 2b. HOUR 6 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 7 DAY 24 YEAR 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD. | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STAGNES Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surveyor | | 12b. KIND OF BUSINESS OR INDUSTRY Surveying |
| 13a. STATE MD | 13b. COUNTY BALTO | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1 B Rambling Oaks Way | |
| 14. FATHER'S NAME FIRST Herbert MIDDLE * LAST WAYS | | 15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE * LAST Moody | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 2 18 18 5658 | | 17. INFORMANT Cecilia Ways ADDRESS CATonsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Lung Ca DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION no op | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 82 , to 5/18 , 19 82 , that (I) (we) last saw the deceased alive on 5/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jen. S. Pan | | DEGREE | | 22c. DATE SIGNED 5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jen. S. Pan | | 22e. ADDRESS St. Agnes Hosp. 900 Canon Ave. 21227 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY Harwood Md. | | 23e. DATE REC'D. BY REGISTRAR MAY 19 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sykesville, Md. | | 25. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 2 7 0 3 | | | | | |
|--|--|---------|--|---|--|------------------------------------|--|---|--|---|--|--|-----|-----------------------------------|----------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | | | | | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| JAMES Harry WEAVER | | | | | | | | | | 5 | | 18 | 82 | 5:10 AM | |
| 2. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| M | | B | | MONTH DAY YEAR 2 26 95 | | | | 87 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| W. Va. | | | | USA | | | | | | Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balt | | | | Nat Maryland Hosp | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| | | | | Md. | | | | Balt | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 335 Calhoun St | | | |
| 14. FATHER'S NAME | | | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | | | | |
| UNK | | | | | | | | | | UNK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| UNK | | | | 215-07-0527 | | | | Elizabeth Byrd 335 N. Calhoun St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) <u>pneumonia</u> | | | | | | | | | | 10 days | | | | | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic heart disease</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Renal failure, Supranuclear palsy</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> , 19 <u>82</u> , to <u>5/18</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| Beth Hewitt | | | | | | | | | | 5/18/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| BETH HEWITT MD | | | | 22 S Greene St. Balt md 2 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 5/20/82 | | Baltimore Cem. | | | | Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm. C. March F/H | | | | 1101 E. North Ave. | | | | MAY 19 1982 [Signature] | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 0 4 | |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MAX WEISS | | 5/23/82 | | 1:36 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| M MALE | Cauc. | 9/25/06 | | 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NEW YORK | USA | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | SINAI HOSPITAL | | INVESTOR | | BUSINESS |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS | | 13d. CITY OR TOWN | |
| MD | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3306 TERRAPIN RD | | BALTO., MD 21208 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| MORRIS AARON WEISS | GUSSIE TITELBAUM | NO | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | | |
| 215-03-7426 | MRS. CECELIA WEISS | | | | |
| 3306 TERRAPIN RD. BALTO., MD 21208 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinsonism</u> | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>3320</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 23, 1982</u> to <u>May 23, 1982</u> that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Jay M Stark MD</u> | | | | <u>5/23/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <u>Jay M STARK MD</u> | | <u>SINAI HOSP</u> | | | |
| | | <u>Primary Care - 578-5850</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | MAY 24, 1982 | CHIZUK AMUNO | | BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | MAY 28 1982 | | <u>James J. [Signature]</u> | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |

15101 82

VIEW M

MD

MD

MD

MD

MD

MD

MD

MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 0 5

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E Wells | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 4 82 | | 2b. HOUR 1113 P M |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1 11 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U S A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY, MD | | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV MD HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE md | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 222 Pindell Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John THOMAS | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY -BOSTON | | 16. ADDRESS -Annapolis, Md. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS NANCY HOLLAND 430 Boston Heights | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Dissected Thoracic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>hypertension</u> | | | | | |
| 19a. DATE OF OPERATION 4-26-82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Type III dissection of aorta with complete occlusion of left I. artery | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/82</u> 19 <u>82</u> to <u>5/4/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/4/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James S Powell | | 22c. DATE SIGNED 5/5/82 | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES S POWELL | | |
| 22e. ADDRESS 22 S Greene St. BALTO MD 21201 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | 23b. DATE 5-8-1982 | 23c. NAME OF CEMETERY OR CREMATORY FOWLERS CHURCH CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE James S Powell | |

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

W 15 15

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--------------------------|---|---------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 2 7 0 6 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2b. HOUR | | | | |
| CARRIE L WELZENBACH | | | | | MAY 15, 1982 3:40 am | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | Cauc. | | 8 MONTH DAY YEAR 19 1892 | | 89 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Church Hospital | | | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 415 N. Curley St | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Joseph Ritger | | | | | Louise Talley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | | | 214-01-7342 | | Louise Hohman 415 N. Curley St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) STROKE | | | | | | | | | |
| 4360 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) this hospital attended the deceased from MAY 5, 19 82, to MAY 15, 19 82, that (I) (we) last saw the deceased alive on MAY 15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated after death. | | | | | | | | | |
| 23. SIGNATURE | | | | | | | | | |
| DEGREE | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| DAVID BUSH MD. | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| CHURCH HOME CORP. | | | | | | | | | |
| 100 N. BROADWAY BALTIMORE, MD; 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| Burial | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 5/18/82 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Holy Redeemer Cem. Baltimore | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Baltimore MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | |
| B. Dabrowski & Son 2818 E. Baltimore St. | | | | | | | | | |
| 25a. DATE SIGNED BY REGISTRAR | | | | | | | | | |
| MAY 18 1982 | | | | | | | | | |

14

Female

Chas.

8 19 1883

89

Ed.

U.S.A.

X

Baltimore City

Baltimore

Church Hospital

Baltimore

Ed.

Baltimore

X

Wid. N. G. G. G.

Joseph

Wid. N. G. G.

Baltimore

Wid. N. G. G.

Ed.

21-11-1902

Wid. N. G. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

Wid. N. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 0 7 | |
|--|--|---|--|---|---|--|--|---|--|---------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH Y. WERHEIM | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 18 82 | | | 2b. HOUR 2:55AM | | | |
| 3. SEX F | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 9 19 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALT. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. BALTIMORE GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY PIEST LUMBER CO. | | | |
| 13a. STATE MID. | | 13b. COUNTY ANN ARUNDEL | | 13c. CITY OR TOWN GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7875 AMERICANA CIRCLE APT-2 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD YOUNG | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IMOGENE CLAY | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-07-8115 | | 17. INFORMANT (DAUGHTER) ROBERTA SALAMON | | ADDRESS: 3001 GLEN BURNIE, MD. 7867 AMERICANA CIRCLE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MCD. 1 MONTH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 4-13 , 19 82 , to 5-18 , 19 82 , that (1) (we) last saw the deceased on 4-18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE PAUL KELLY, MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5-18-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL KELLY, MD | | | | 22e. ADDRESS 3001 So. HARVARD ST. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE NORFOLK VA. | | | | | |
| 24. FUNERAL DIRECTOR NAME FLEMING FUNERAL SERVICE | | | | ADDRESS 21018 BENSON, MD. | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

MEDICAL CERTIFICATION

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 0 8
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN BERNARD WERNIG SR. | | 2a. DATE OF DEATH MONTH DAY YEAR 05 - 24 - 82 | | 2b. HOUR MIN. 2 AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 08 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICE WRITER | | 12b. KIND OF BUSINESS OR INDUSTRY AUTO DEALER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | 13b. COUNTY --- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH WERNIG | | 15. MOTHER'S MAIDEN NAME MIDDLE S. KENDALL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WW II 219-10-8204 | |
| 17. INFORMANT ADDRESS TERRY BENSON RT. 1 BOX 256A CHESTER, MD. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> 5334 DUE TO, OR AS A CONSEQUENCE OF (b) <u>bleeding Papillary Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| <u>Chronic Obstructive Pulmonary disease</u> | | | | | | | |
| 19a. DATE OF OPERATION 5/21/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding (UAC). | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>22nd 5/24/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>K.F. ABRAHAMSON</u> | | DEGREE MD. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/24/82. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.F. ABRAHAMSON | | 22e. ADDRESS Bon Secours Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 05-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | 24b. ADDRESS 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12709 | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Allen Robert West Sr. | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> 5 18 1982 | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 18 1982 | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1027 Cathedral Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1027 Cathedral St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard H. West | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia O'Mara | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) .No | | | | 16b. SOCIAL SECURITY NO. 217-07-1584 | | 17. INFORMANT ADDRESS Mary A. West 6401 Loch Raven Blvd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 5-18-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 & 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| FOR 1. STATE REGISTRAR | | | | | 8 2 1 2 7 1 0 CERTIFICATE OF DEATH REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EMALINE WEST | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 7 82 2b. HOUR 6:56 P M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 2, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md 13c. COUNTY Howard 13d. CITY OR TOWN Jessup | | | | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13f. STREET ADDRESS Rt 1 Box 239 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sampson Helburn | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liza Pate | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | 16b. SOCIAL SECURITY NO. 244 20 9790 | | 17. INFORMANT ADDRESS South Port Roy B. Lee PO Box 10088 North Carolina | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronicity & possible R. lung pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NONE. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 4 , 19 82 , to May 7 , 19 82 , that (I) (we) lost saw the deceased alive on May 6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Charles W. Hicks MD | | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 5-07-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Hicks MD | | | | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

UNION MEMORIAL HOSPITAL

LITTON JAMES WOLF

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12711 | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE WHEATLEY | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-12-82 | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 9-1-17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-12-82 | | 7b. HOUR M 7:12P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3002 Hudson Street | | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3002 Hudson Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY Jacobs | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louemma Jones | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 407-18-8684 | | 17. INFORMANT ADDRESS Virgie A. Stump 1332 E. Fort Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease and 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) obesity DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margaret DeKoele | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 5-13-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/17/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park | | | |
| 24. FUNERAL DIRECTOR NAME Charles L. Stevens Funeral Home, Inc | | | | ADDRESS 1501 E. Fort Ave | | | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | | |
| 23d. LOCATION CITY OR TOWN Baltimore | | | | COUNTY Maryland | | | | STATE | | | |

11 9 1 2 6

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

[Faint, illegible handwritten text at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 1 2 7 1 2 REG. NO. | | | | |
|--|--|---|--|--|---------------------------------|---|--|--|-----------------|
| 1- FOR STATE REGISTRAR Nellie G. WHEELER | | | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | 2b HOUR |
| 1. DECEASED NAME FIRST MIDDLE LAST NELLIE G WHEELER | | | | | may 28 82 | | | | 2 50 P M |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 3 12 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD Md. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker | | 12b KIND OF BUSINESS OR INDUSTRY Plastic Laminate | |
| 13a. STATE MD | | 13b. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1132 W. Lombard ST | | | |
| 14 FATHER'S NAME FIRST MIDDLE George F. | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kelty | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO. 220-22-4158 | | 17. INFORMANT ADDRESS Leonard Swigert/1132 W Lombard St/Balto Md | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, etc 5570 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septic shock, Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Gangrene small bowel APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs 36 hrs | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 5/29/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair, Gangrene 2 small bowel | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11/82 19 82 , to 5/28/ 19 82 , that (I) (we) last saw the deceased alive on 5/28/ 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BADRO | | 22e. ADDRESS SRB 14 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 05/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematorium | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Maryland 21228 | | | |
| 24 FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets | | ADDRESS Balto Md 21223 | | 25a. DATE BY REGISTRAR 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

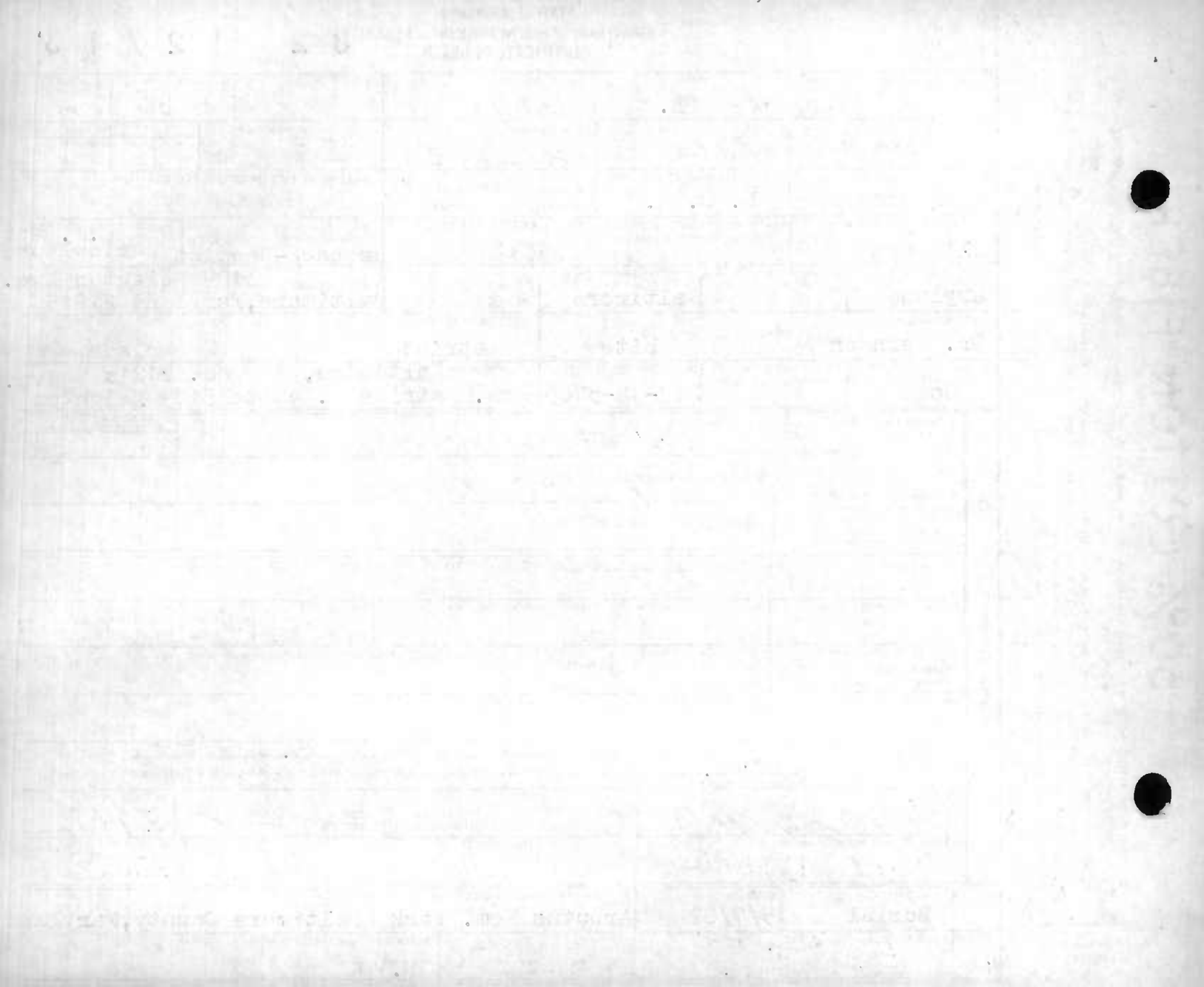
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 7 1 3' REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Katrine E. White</i> | | | |
| 3. SEX <i>Female</i> | | | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 21 23</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>59</i> YRS. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Research-Chemist</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Dr. Herndon White</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katrine Nelson</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>219-12-5769</i> | | 17. INFORMANT ADDRESS Md. 21215 Ave. <i>Mrs. Katrine N. White 3109 Leighton</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC arrest</i> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>hx of COPD X10 YRS</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 4</i> 19 <i>82</i> , to <i>May 7</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>May 4</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Jay MSTAR</i> | | | | DEGREE | | 22c. DATE SIGNED <i>5/4/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jay MSTAR</i> | | | | 22e. ADDRESS <i>Sinai Hospital, Baltimore</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>5/7/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore County, Maryland</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>HERBERT E. NUTT</i> | | | | ADDRESS <i>BALTIMORE MARYLAND 21216</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 5 1982</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

24. FUNERAL DIRECTOR NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 7 1 4 REG. NO. | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Laura A. White | | | | 2a. DATE OF DEATH MONTH 5 DAY 1 YEAR 1982 | | | |
| 1 SEX female | | 4 RACE black | | 5. DATE OF BIRTH MONTH 6 DAY 29 YEAR 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1709 Latrobe Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1709 Latrobe Street | |
| 14 FATHER'S NAME FIRST Henson MIDDLE Moore LAST Moore | | | | 15 MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE Browner LAST Moore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-5009 | | 17 INFORMANT ADDRESS Mable Phillips 1717 Latrobe Street | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3949 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL VALVE DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 50 YEARS " |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from MAY 19 80 to MARCH 19 82 , that (1) we last saw the deceased alive on 3 MARCH 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN C. ACHUFF, M.D. | | | | 22c. DATE SIGNED 5/4/82 | | 22d. ADDRESS THE JOHNS HOPKINS HOSPITAL BALTIMORE 21205 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md Nat Mem Park | | 23d. LOCATION CITY OR TOWN Laurel COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | |



General Practitioner
100 High Street
London E1 1AA

Dr. J. Smith
100 High Street
London E1 1AA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 1 5 | |
|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRMS MARCELLA MIDDLE WHITE MARCELLA F WHITE | | | | 5-2-82 YEAR 5/2/82 5:15 P M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 9-12-14 MONTH 9 DAY 12 YEAR 14 | |
| 7a. BIRTHPLACE Balto. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS, LAST BIRTHDAY) 67 YRS. 67 MONTHS 67 DAYS 67 HRS. 67 MIN. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN A NURSING HOME, GIVE RESIDENCE BEFORE ADMISSION) Balto. City Hosp. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 12a. USUAL OCCUPATION governess | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lee Hare | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Erdman | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 214-40-0670 | | 17. INFORMANT John S. White 4320 Clareway 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5314 RESPIRATORY ARREST - CARDIAC DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIC/HYPOXIC BRAIN DAMAGE DUE TO, OR AS A CONSEQUENCE OF (c) UPPER GI HEMORRHAGE & HYPOTENSION 1 MON. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 4/2/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING GASTRIC ULCER | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> A) WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1 1982, to 5/2 1982, that (I) (we) lost saw the deceased alive on 5/1 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE R Scott Stumpe | | DEGREE MD | | 22c. DATE SIGNED 5/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R SCOTT STUMPE MD | | 22e. ADDRESS BALTIMORE CITY HOSPITALS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5-5-82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane 21213 | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8212716 | |
|--|-------------------------|---|---|--|--|---|---|---|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Pandora White | | | | | | 2b. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 5 YEAR 28 19 82 | | 2b. HOUR M 3:15 | | | |
| 3. SEX Female | 4. RACE Negro | 5. DATE OF BIRTH MONTH 3 DAY 11 YEAR 1960 | 6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH 5 DAY 28 YEAR 19 82 | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2849 W. North Avenue | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2020 Edmondson Ave. 2nd Fl. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Haskins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veltina Lawrence | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Veltina Brown 2020 Edmondson Avenue | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke & soot inhalation & acute carbon monoxide intoxication 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:33 PM 5 28 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2849 W. North Ave. Balto. Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | | DATE SIGNED 5/28/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial | | | 23b. DATE 6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i> | | | | |

0.151 12

17



RECEIVED
JAN 10 1960
U.S. AIR FORCE
HONOLULU



20 E

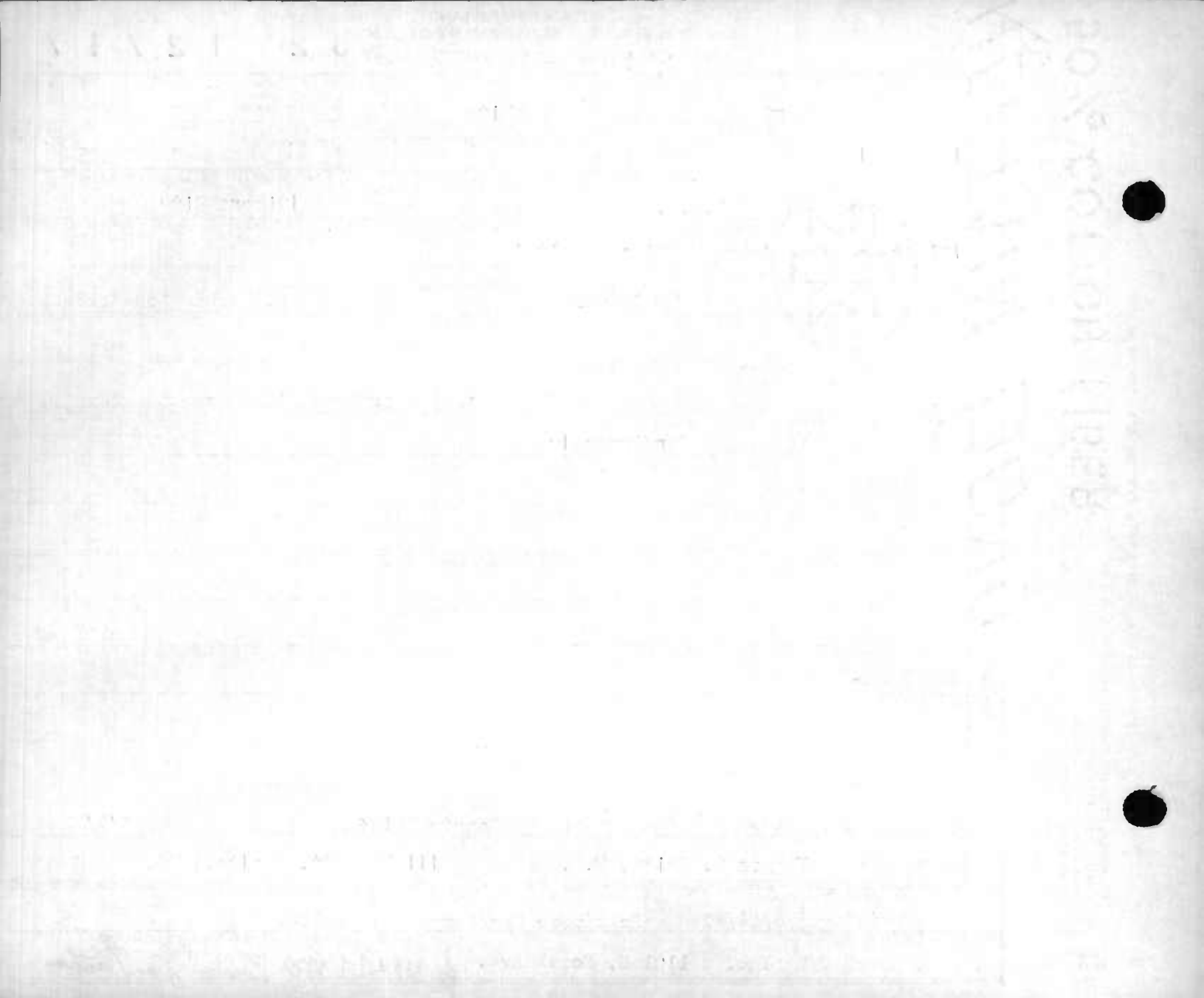
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 7 1 7

| | | | | |
|---|--|--|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE |
| Robert | | Male | | Black |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. CITIZEN OF WHAT COUNTRY? |
| 1 20 09 | | 73 YRS. | | U.S.A. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH |
| North Carolina | | Baltimore City, | | Baltimore |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Johns Hopkins Hospital | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN |
| MD | | | | Baltimore |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) |
| unkn | | Lillie Miller | | No |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS |
| 240-03-4787 | | Mazel Thornton | | 1021 Branch Water Ct. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomegaly</u> 4293 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE <u>Thomas D. Smith</u> | | TITLE (SPECIFY) M.D. Deputy Chief | | DATE SIGNED 5/9/82 |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | |
| Thomas D. Smith, M.D. | | III Penn St. Balto., MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY |
| Burial | | 5/14/82 | | Baltimore Cemetery |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Wm. C. March F/H, Inc. | | 1101 E. North Ave. | | MAY 11 1982 Frances Jan. Nathan |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 1 8 REG. NO. | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) SARAH WHITE XXXXX Ellen White | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 5 82 | | | | 2b. HOUR 4⁴⁵ AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 - 23 - 1910 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN DUNDALK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6779 WOODLEY RD. 21222 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM SHUE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ELIZABETH CORNWALL | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217.22.5848 | | 17. INFORMANT ADDRESS KATHLEEN K. WHITE 3005 LIBERTY PKWY. 21222 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 82 , to 5/5 , 19 82 , that (I) (we) last saw the deceased alive on 5/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE PARNES | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/5/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PARNES | | | | 22e. ADDRESS B. C. H. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/8/1982 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ELKBRIDGE MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | | |

U. S. I. 1

RECEIVED

DATE

TIME

TO



RECEIVED

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 1 9 | |
|---|--|---|--|---|--|--|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Snow (Snode) (Snodie) White | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 31, 1982 | | | | 2b. HOUR 3:45P M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH 3 MONTH 12 YEAR 92 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 501 Dolphin St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Vera B. Thigpen 619 E. 41st. St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural Effusion</u> 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 15, 19 82, to May 31, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 31, 19 82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jim-Jer Hwu M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/31/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jim-Jer Hwu, M.D. | | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | 25b. REGISTRAR'S SIGNATURE James Santhorn | | | |

Nov 21 1952

White

Smith (1952)

Bellevue City

Bellevue Central Hospital

Bellevue

Nov 21 1952

Bellevue Central Hospital

Bellevue Central Hospital

Bellevue Central Hospital



Nov 21 1952

Nov 21 1952

Nov 21 1952

Bellevue Central Hospital

Bellevue Central Hospital

Handwritten signature and date: Nov 21 1952

Item 5 567 5/24/82 gj

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 2 0

REG. NO.

| | | | | | | | | | | |
|--|------------------------------|---|---|--|--------------------------------------|--|-----------------|--|------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| LELEA | | | | WHITEHEAD | 5-12-82 | | | | | 830 PM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | BLACK | | MONTH 3 DAY 22 YEAR 15 82 | | 67 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| SOUTH CAROLINA | USA | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | MERCY HOSPITAL | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MARYLAND | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 910 W. FRANKLIN ST. | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| JIM | | HEATH | | BEULAH JOHNSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | N/A | | DAISY PEAY 910 W. FRANKLIN ST. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCITES</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>82</u> , to <u>5/12</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| <u>LARRY FELDMAN</u> | | MD | | | | | | 5/12/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| LARRY FELDMAN | | MERCY HOSP BALT. MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | | | |
| BURIAL | | 5/18/82 | | MT. CALVARY CEM. | | ANNE ARUNDEL MD. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | |
| Wm. C. Marchese | | | | 5 MAY 17 1982 | | | | James J. [Signature] | | |

MEDICAL CERTIFICATION

9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

0-2-15-20

0-2-15-20

11

0-2-15-20

0-2-15-20



0-2-15-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 2 1 REG. NO. | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH H. WHITEHILL | | | | | | 5 23 82 | | 5 40 P M | | | |
| 2. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3 23 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS 2 0 | | IF UNDER 28 HRS HOURS MINUTES 0 4 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | 10. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | |
| 11. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN Owings Mills | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 61 MERNIAN COURT | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PAV Kev | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Un Known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. 217-03-7837 | | 17. INFORMANT ADDRESS Irving Whitehill 133 Shetland Cir. Reisterstown Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5324 Cardiac & Respiratory arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombotic Hemorrhage from duodenal ulcer (c) Chronic duodenal ulcer | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Arteriosclerotic Heart Disease - Chronic Heart Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 1 1975 to MAY 23 1982 , that (I) (we) saw the deceased alive on MAY 23 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Manuel Levin DEGREE MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/23/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D. | | | | | | 22e. ADDRESS 6101 PK HBS AVE BALTO MD 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | | | 23b. DATE May 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. PK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD 21228 | | | |
| 24. FUNERAL DIRECTOR H. Schmitt ADDRESS Owings Mills, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 2 2 REG. NO. | | |
|--|--|---|--|---|--|---|--|---|-----------------------------------|---|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST JESSIE | | MIDDLE W. | | LAST WHITNEY | | 2a. DATE OF DEATH MONTH DAY YEAR 5 21 82 | | | 2b. HOUR 10:10A | |
| 3 SEX F | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Pa. | | | | 13b. COUNTY Lucinda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 160 G | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Willison | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Somers | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 169 01 4125 | | 17 INFORMANT ADDRESS Mrs. Janet Anderson Emporia, Kansas | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dehydration & starvation</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic squamous cell CA of Esophagus 2 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> , 19 <u>82</u> , to <u>5/21</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John 2010</u> | | | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LIM | | | | 22e. ADDRESS SINAI HOSP. OF BALTIMORE, MD 21215 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Transit | | 23b. DATE May 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Penn-Lincoln Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE N. Huntingdon, Westmoreland Co. Penna. | | | | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. | | | | ADDRESS 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1982 | | 25b. REGISTRAR'S SIGNATURE <u>James J. Harrison</u> | | | | |

100-4934

ALBANY, N.Y.

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

100-4934

X

100-4934

100-4934

100-4934

100-4934

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the coffin after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 2 7 2 3 | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | |
| 6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | 17 ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral embolism. DUE TO, OR AS A CONSEQUENCE OF (c) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION | |
| 22a. I certify that (this hospital) attended the deceased from 5-2-82 to 5-2-82, that (we) last saw the deceased alive on 5-2-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (do not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

2.2.1.5.1

0

Handwritten notes at the top of the page.



Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

Handwritten text below the diagram.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by office.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|
| <div style="text-align: right;">8 2 1 2 7 2 4</div> <div style="text-align: center;"> CERTIFICATE OF DEATH FOR 1. STATE REGISTRAR </div> | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruth Louise Whittle</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5 29 82</i> | | | | | 2b. HOUR <i>11:30 PM</i> |
| 3. SEX <i>Female</i> | | 4. RACE <i>Cauc</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 20 1914</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS <i>67</i> YRS. | | IF UNDER 24 HRS. HOURS MIN. <i>11:30 PM</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>US</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD | | | | |
| 10. CITY OR TOWN OF DEATH <i>Balt.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>---</i> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> | | | | | 13b. COUNTY <i>Balt</i> | | 13c. CITY OR TOWN <i>Pikesville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>706 Templecliff Rd</i> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick O Stueber</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eleanor Renno</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <i>No</i> | | | | | 16b. SOCIAL SECURITY NO. <i>214-03-7941</i> | | 17. INFORMANT <i>William E. Whittle</i> ADDRESS <i>Pikesville, Md 21208</i> <i>706 Templecliff Rd.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>5939</i> IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ESRD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/29</i> , 19 <i>82</i> , to <i>5/29</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/29</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>W. Kellner</i> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <i>5/29/82</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Kellner</i> | | | | | 22e. ADDRESS <i>Sinai Hosp</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>6/2/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore Md</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, Inc.</i> | | | | | 24b. ADDRESS <i>8728 Liberty Rd. Randallstown, Md.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1982</i> | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | | |

1251 20

RECEIVED

1251 20

RECEIVED

RECEIVED

1251 20

RECEIVED

RECEIVED

RECEIVED

1251 20

RECEIVED

RECEIVED

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

RECEIVED

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

RECEIVED

1251 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M
(VR A 15 (4) 9/74)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 2 7 2 5 | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| JOHN EDWARD WHOLEY SR | | | | 05 02 82 | | | | | | | | 330 p M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| MALE | | White | | 08 17 05 | | 76 | | MONTHS | | DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MD | | USA | | | | Balto City MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Balto | | South Baltimore Gen Hospital | | Maintenance Leader/company | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md | | A.A. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 6642 Whitmore Ct. | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| George Henry Wholey | | | | Catherine Smith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | | | 215 07 7625 | | John E. Wholey Jr. | | 302 5th Ave. Balto Md. 21225 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | | | | | | |
| 4100 | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| Renal failure | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 19 19 82 to MAY 2 19 82, that (I) (we) last saw the deceased alive on MAY 2 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| A Barnett | | | | | | | | | | | | MD | | 5-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | 22e. ADDRESS | | | |
| ANNA BARNETT | | | | | | | | | | | | 3001 S Hanover St | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | | | |
| Burial | | | | 5/5/82 | | Cedar Hill Cem | | Brooklyn | | | | A. J. Gonce | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE REC'D. BY REGISTRAR | | 25c. DATE REC'D. BY REGISTRAR | | 25d. DATE REC'D. BY REGISTRAR | | 25e. DATE REC'D. BY REGISTRAR | | | |
| George J. Gonce | | | | 4001 Ritchie Hwy | | MAY 3 1982 | | Francis J. Gonce | | | | | | | |

1950

DATE 12 17 50

CITY

X

(Signature)

ST 10 1950

CHIEF

20% COTTON FIBER



ST 10 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 2 6 | |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Helen Wicklin | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 20 82 | | 2b. HOUR M | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 1 8 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4901 Alson Drive, Balto. Md. 21229 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4901 Alson Drive, Balto. Md. 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Wicklin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Amrein | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 212-09-03634 | | 17. INFORMANT ADDRESS 1960 Hunterfield Rd. Maitland Fla. 32751 Mr. G.W. Wicklin | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis - Diverticulitis</u> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI. Bldg Diverticulitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis, Colostomy, and peptic Ulcer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/70</u> , 19 <u>80</u> , to <u>5/20</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive <u>5/20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE May 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR Truman Schwab 5151 Balto. National Pike | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 would be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 7 2 7 REG. NO. | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MOLLY WIENER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 - 10 - 82 | | | | 2b. HOUR 1245 A.M. | | | |
| 3 SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY HECHT CO. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN RANDALLSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 16 MILLSTONE RD. #21133 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN WIENER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 220-07-1343 | | 17. INFORMANT MRS. GLORIA SEIDEL 16 MILLSTONE RD. RANDALLSTOWN, MD 21133 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 5693 DUE TO, OR AS A CONSEQUENCE OF (b) PERIOD BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dehydration | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 03-23 , 19 77 , to 05-10 , 19 82 , that (I) (we) lost saw the deceased alive on 05-10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE B. ZAN-WIN, MD. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5-10-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAN-WIN, MD. | | | | 22e. ADDRESS LEVINDALE GERIATRIC BALTO 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 12, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE James J. K... | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

10-15-65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 2 8 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) AKA: TEOFILA BARBARA WIERUSZEWSKA BARBARA WIERUSZEWSKI | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-31-82 | | 2b. HOUR 6:10 PM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Poland | | 13b. CITY OR TOWN 81-209 Gdynia | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 106/15 Czerwonych Kosynierow | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alojzy Tabencka | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena (UNKNOWN) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16a. SOCIAL SECURITY NO. --- | | 17. INFORMANT ADDRESS Maciej Wieruszewski, 8002 Stratman Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4300 SUBARACHNOID HEMORRHAGE IMMEDIATE CAUSE (a) 10 DAYS DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ANEURYSM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION 5-26-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL ANEURYSM | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 5-23-82 to 5-31-82 , that (I (we) lost saw the deceased alive on 5-31-82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Chas | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-31-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRASEKHARAN NAIR | | 22e. ADDRESS BALTIMORE CITY HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE June 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gdynia-Witomino | | 23d. LOCATION CITY OR TOWN COUNTY STATE Gdynia Poland | |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1982 REGISTRAR'S SIGNATURE James J. Martin | | | |



CHANDLER

CHANDLER, J. W. 1917

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

CHANDLER, J. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 2 9 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST BERTHA ANNA WILCHINSKI | | | | MONTH DAY YEAR 05 22 82 | | | |
| 3 SEX | | | | 2b. HOUR | | | |
| Female | | | | 7:00A M | | | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| White | | MONTH DAY YEAR 2 7 10 | | 72 YRS. | | IF UNDER 74 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | 1342 Glyndon Avenue 21223 | | Homemaker | | | |
| 13a. STATE | | | | 13b. STREET ADDRESS | | | |
| Maryland | | | | 1342 Glyndon Avenue 21223 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST Michael Przywara | | | | FIRST MIDDLE LAST Anna Galka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| NO | | | | 217-40-0010 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Charles J. Wilchinski | | | | 21223 1342 Glyndon Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute CORONARY insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | 21g. DATE SIGNED 5/23/82 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>82</u> , to <u>05/22</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/19</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Kuang-yen Huang M.D.</u> | | | | 22c. ADDRESS 517 SCOTT ST 21230 | | 22d. DATE SIGNED 5/23/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | | | 22f. ADDRESS 517 SCOTT ST 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/26/82 | | Crest Lawn Mem. Gar. | | Marriottsville Howard, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | | | |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 3 0
REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| | | WILKINS, Ollie J. SR | | 5-6-82 | | 10:20 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| M | | B | | 6 13 09 | | 72 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VIRGINIA | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | BON SECOUR HOSPITAL | | LONGSHOR MAN STEAMSHIP TRADING CO. | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3612 GRANTLEY ROAD | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| MANUEL | | BERTHA | | No | | 705-10-9336 | | ROSA MAE WILKINS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| PART I. DEATH WAS CAUSED BY: | | | | 4039 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| IMMEDIATE CAUSE (a) RENAL FAILURE | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | (b) NEPHROTIC SYNDROME | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | SEPSIS | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. LOCATION | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | CITY OR TOWN | | COUNTY STATE | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| above, the deceased alive on | | CURTIS E DAVIS MD | | | | MAY 11 1982 | | | |
| and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| | | CURTIS E DAVIS MD | | 1940 W. BALTIMORE ST 21223 | | MAY 11 1982 | | Curtis E Davis | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D BY REGISTRAR | |
| BURIAL | | 5/11/82 | | GARDEN OF ETERNITY | | CITY OR TOWN | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. CITY OR TOWN | | 24d. COUNTY STATE | |
| DONALD E. GLOVER | | VERNON BALIEX | | 1348 CALHOUN ST | | BALTIMORE | | MD | |

Baltimore
Ben & Edouard Hospital
Baltimore City

Baltimore
Edouard Hospital
Baltimore City

2/1/73 (continued)
David E. Green

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| <div style="text-align: right;">8 2 1 2 7 3 1</div> <div style="text-align: center;"> CERTIFICATE OF DEATH REG. NO. </div> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice M. Williams | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 - 17 - 82 | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 - 01 - 89 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hanover, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Middtown Home, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3015 Westwood Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lucan James | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora James | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 062-16-0722 | | 17. INFORMANT ADDRESS Medical Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Blender | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben Reider, M.D. | | | | | 22e. ADDRESS 1406 Crain Highway, South | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutis Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Russ Funeral Home, 2222 W. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Ruben Reider | | | | |

10

252

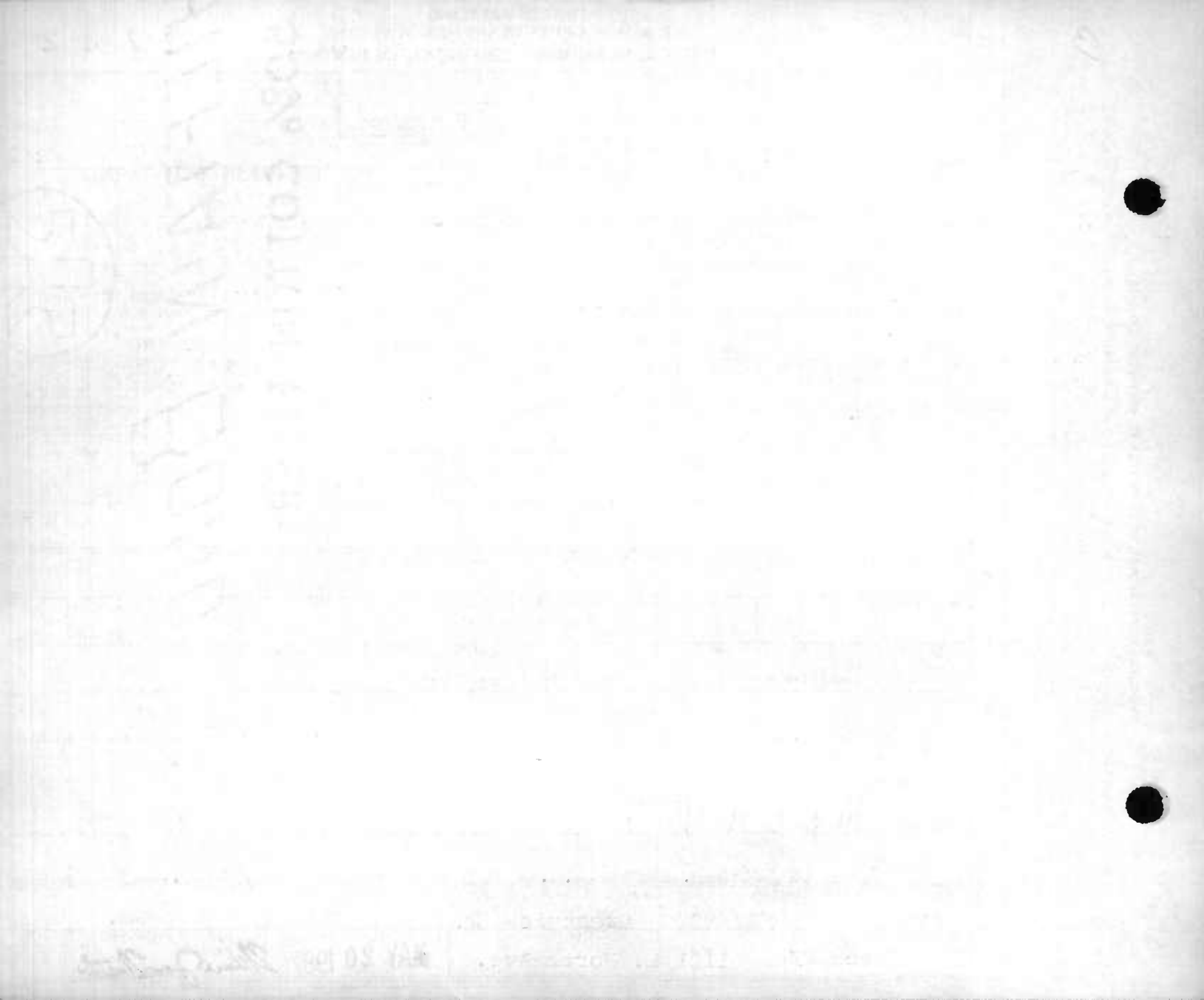
• • •

• 1970 •

100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 1 2 7 3 2 | |
|--|--|----------------------|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Anita Williams | | | | | | 2a. DATE OF DEATH 5 15 19 82 | | | | 2b. HOUR 1:45 | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH 1 2 70 | | 6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 5 15 19 82 | | 2d. HOUR 1:45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2781 Tivoly Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Balto. | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS 2781 Tivoly Avenue | |
| 14. FATHER'S NAME James E. Williams | | | | 15. MOTHER'S MAIDEN NAME Deloris Brown | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A | | | | 17. INFORMANT Audrey Mitchell ADDRESS Ft. Bragg N.C. 400 Searight Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 8902 (b) (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 12:29AM 5/15/82 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR housefire | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION CITY OR TOWN Baltimore City, MD COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 5/15/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/22/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Crestview Cem. | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H | | | | ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 | | | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 2 7 3 3
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|------------|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Clarence | | MIDDLE (Clarence) | | LAST Williams | | 2e. DATE OF DEATH | | MONTH 5 | | DAY 7 | | YEAR 82 | | 2b. HOUR 3:15 P.M. | | | | | | | |
| 3 SEX M | | 4 RACE B | | 5. DATE OF BIRTH | | MONTH 9 | | DAY 4 | | YEAR 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Md | | | | | | | | | | | | | | | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2306 E. Chase Street | | | |
| 14. FATHER'S NAME FIRST Charlie | | | | MIDDLE | | | | LAST Williams | | | | 15. MOTHER'S MAIDEN NAME FIRST Alice | | | | MIDDLE Moore | | | | LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 241-40-6139 | | | | 17. INFORMANT Clarence Williams 2306 E. Chase St | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio pulmonary collapse</u> 5738 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u> | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> , 19 <u>82</u> , to <u>5/7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John Stale</u> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5/7/82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Stale</u> | | | | 22e. ADDRESS Baltimore City Hospital | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/13/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave | | | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u> | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 3 4

REG. NO.

1. FOR
STATE
REGISTRAR

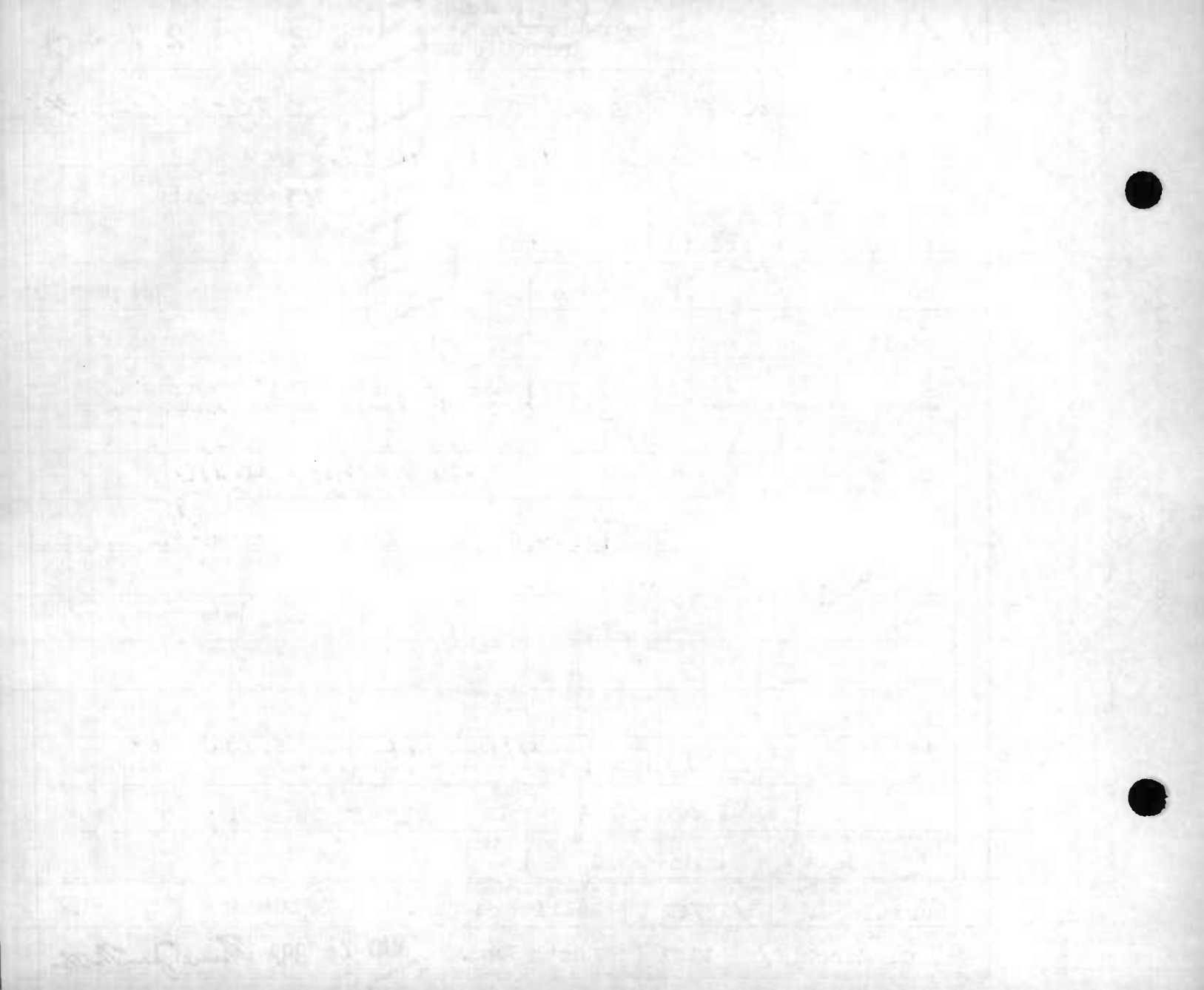
| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Cornella Williams</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>05-22-82</i> | | | 2b. HOUR <i>1:30 P.M.</i> | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>1 4 10</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>72 yrs</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>MD</i> | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Odell Williams</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Roxie Reynolds</i> | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i> | | | |
| 17. SOCIAL SECURITY NO. <i>246-18-2141</i> | | | 18. INFORMANT ADDRESS <i>Barbara Hines 5917 Cherrywood Terr.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent stroke left</i> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Thrombotic Myocardial Infarction</i> (c) <i>Hypertensive Cardiomyopathy</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <i>Aspiration Pneumonia</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> 19 <i>82</i> to <i>5/122</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/122</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Rifat Abouy</i> | | | DEGREE <i>MD</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rifat Abouy</i> | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>5/28/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i> | | | | | ADDRESS <i>1101 E. North Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 26 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Anne J. Nathan</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. NUMBER 7 FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12735 | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) Deloris (Delores) Williams | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 15 YEAR 1982 | | 2b. HOUR M | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 45 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD MONTH 5 DAY 15 YEAR 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2781 Tivoly Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2781 Tivoly Avenue | | | |
| 14. FATHER'S NAME FIRST Lum MIDDLE Brown LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Flossie MIDDLE McKinner LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Eloise E. Rice 1906 E. 31st St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) 8902 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 12:29AM MONTH 5/15 YEAR 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) housefire | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> xx | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) 2781 Tivoly Avenue, Baltimore City, MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie Bethell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 5/15/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, MD. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crestview Cem. | | | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) Cairo, Ga. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | |

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 3 6 | |
|---|--|---|--|---|--|--|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Elsie M. Williams | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 27, 1982 | | | | 2b. HOUR 10:55p | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 16 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4902 Faint Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Jaruis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anio Laino | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212-14-2400 | | 17. INFORMANT Albin R. Williams | | ADDRESS 4902 Faint Avenue Balto., MD. 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 1820 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Endometrial cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , <u>82</u> , to <u>5/27</u> , <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> , <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H.P. Sullivan Jr MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/27/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY P SULLIVAN JR MD | | | | | | 22e. ADDRESS 600 N. Wolfe St Balto, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/1/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 3 1982 [Signature] | | | | | |

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

✓

1. Name of the plant or animal
2. Date of collection
3. Locality
4. Collector's name
5. Number of specimens
6. Remarks

7. Description of the specimen
8. Drawing of the specimen
9. Photograph of the specimen
10. Other notes

11. Name of the collector
12. Date of collection
13. Locality
14. Collector's name
15. Number of specimens
16. Remarks

17. Name of the collector
18. Date of collection
19. Locality
20. Collector's name
21. Number of specimens
22. Remarks

23. Name of the collector
24. Date of collection
25. Locality
26. Collector's name
27. Number of specimens
28. Remarks

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 7 3 7 | |
|---|----------------------|---|--|--|--|---|--|---|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) James E. Williams | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH 5 DAY 15 YEAR 19 82 | | 2b. HOUR M | | | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH 2 DAY 28 YEAR 41 | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 7c. DATE PRONOUNCED DEAD MONTH 5 DAY 15 YEAR 19 82 | | 7d. HOUR 1:45 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2781 Tivoly Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2781 Tivoly Ave. | | | |
| 14. FATHER'S NAME FIRST Willie MIDDLE Williams LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Olivia MIDDLE Mitchell LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Audrey Mitchell | | ADDRESS 400 Searight Dr. Ft Bragg, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Smoke and soot inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:29AM 5/15 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) housefire | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET 2781 Tivoly Avenue CITY OR TOWN Baltimore COUNTY City STATE MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Audrey Mitchell | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 5/15/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY Crestview Cemetery | | 23d. LOCATION CITY OR TOWN Cairo COUNTY Gerogia STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE Anne J. [Signature] | | | | | |

THE UNIVERSITY OF CHICAGO
LIBRARY

COLLEGE OF ENGINEERING
BUILDING 10
CHICAGO, ILL.

1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHAM - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 2 7 3 8 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN WALTER WILLIAMS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 17 82 | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR 10-2-1915 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind. | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218 | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Book. City | | | | |
| 13a. STATE Ind. | | | | | 13b. COUNTY Baltimore | | | | |
| 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS 1529 Ramsay St. 21223 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles R. Williams | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brogan | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 215-16 1196 | | | | |
| 17. INFORMANT Carol Baker | | | | | ADDRESS 1529 Ramsay St. 21223 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Postobstructive Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Squamous Cell Carcinoma of Lung Metastatic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET | | | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 27, 19 82, to MAY 17, 19 82, that (X) (we) last saw the deceased alive on MAY 17, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (we) (did) (do) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE D. Schreiner M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22c. DATE SIGNED 5-17-82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Schreiner M.D. | | | | | 22e. ADDRESS VAMC 3900 LOCH RAVEN BLVD 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 5-21-1982 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Vet Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. Co. Ind. | | | | |
| 24. FUNERAL DIRECTOR Frank Cowan & Son, Inc. 901 N. Calhoun St. | | | | | 25. MAY 15 1982 | | | | |

MEDICAL CERTIFICATION

99

BP

NOV 10 1904



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 3 9

REG. NO.

| | | | | | |
|---|-------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARCELLA GOSNELL WILLIAMS | | 2a. DATE OF DEATH MONTH DAY YEAR 5 30 82 | | 2b. HOUR 4 45 AM | |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 05 05 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co. MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L Deaton Medical Center | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Balto. | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8173 Old Mill Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isiah Gosnell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Keller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218 099422 | | 17. INFORMANT Donald Williams | |
| | | | | ADDRESS 8173 Old Mill Rd. Pasadena, Md | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4029

IMMEDIATE CAUSE (a) **Hyperbolic CVD**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
X PALS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CVA, multiple

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 82 to 5/30 19 82 , that (we) last saw the deceased alive on 5/30 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE J.R. Gladue | | DEGREE | | 22c. DATE SIGNED 5/31/82 | |
| 22d. THE PHYSICIAN'S NAME (TYPE OR PRINT) J. R. Gladue | | 22e. ADDRESS 611 So. Charles ST | | | |

| | | | | | |
|---|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md | | 24. FUNERAL DIRECTOR NAME ADDRESS Leroy A Syett 4600 Liberty Hgts | | 25a. DATE REC'D. BY REGISTRAR JUN 9 1982 | |
| 25b. REGISTRAR'S SIGNATURE Thomas J. Smith | | | | | |

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

UNITED STATES OF AMERICA



ITJ

UNITED STATES OF AMERICA

X

UNIT

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 4 0 | |
|--|--|---|--|---|--|--|--|---|-----------------------------------|---|--|
| FOR 1- REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE WILLIAMS LAST | | | | | | 2a. DATE OF DEATH MONTH MAY DAY 30, YEAR 1982 | | 2b. HOUR 7:50PM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 7 DAY 27 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1210 N. Eden Street | | | |
| 14. FATHER'S NAME FIRST Henry MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Cordelia MIDDLE LAST Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Frank L. Williams | | | | ADDRESS 1210 N. Eden Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>24 hrs</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>82</u> , to <u>5/30</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/30</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert C. Kleiner MD</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/30/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. KLEINER MD | | | | | | 22e. ADDRESS JOHNS HOPKINS HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | 23d. LOCATION CITY OR TOWN Balto. Co. COUNTY STATE MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. ADDRESS 1101 E. North Ave | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 3 1982 <u>James J. Smith</u> | | | | | |

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 7 4 1 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Michelle Cassandra Williams | | | | | | | | | | 2. DATE KNOWN OF DEATH 5 15 19 82 | |
| 3. SEX female 4. RACE black 5. DATE OF BIRTH 7 2 76 6. AGE (IN YEARS LAST BIRTHDAY) 5 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fla. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | | | | | | 2d. HOUR 1:45A | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2781 Tivoly Avenue 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 2d. HOUR 1:45A | |
| 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS 2781 Tivoly Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME James E. Williams 15. MOTHER'S MAIDEN NAME Deloris Brown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? N/A 16b. SOCIAL SECURITY NO. N/A 17. INFORMANT Audrey Mitchell ADDRESS Ft. Bragg, N.C. 400 Searight Dr. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 5/15/82 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? housefire 20. AUTOPSY? YES | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 12:29 AM 5/15/82 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:29 AM 5/15/82 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) housefire | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2781 Tivoly Avenue, Baltimore City, MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Koroll M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5/15/82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. ADDRESS 111 Penn Street, Balto MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 5/22/82 23c. NAME OF CEMETERY OR CREMATORY Crestview Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Cairo, Ga. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 25b. REGISTRAR'S SIGNATURE Phane Jan... | | | | | | | | | | | |

100%

COLLIER

DOWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 4 2 | |
|---|--|--|--|---|---|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE WILLIAMS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-08-82 | | | 2b. HOUR 8:12 A.M. | | | |
| 3. SEX FEMALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 07-12-05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Petersburg Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) North Charles Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY BALTO. | | 13c. STREET ADDRESS 1701 Eutaw Place | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Anderson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Jones | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-124573D | | 17. INFORMANT Mrs. Lorraine King | | ADDRESS 822 N. Carey St 2nd Floor | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05-01- 19 82 , to 05-08- 19 82 , that (I) (we) last saw the deceased alive on 05-08- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Cesar Gariboa M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 5-8-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR GARIBOA, M.D. | | | | | | 22e. ADDRESS 90 N. CHARLES GEN. HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | | | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

NOV 10 1913

U. S. DEPT. OF AGRICULTURE

Check

U. S. D.

Patented

Gold

North Carolina

1913

Patented

Charles H. Johnson

Patented

U. S. DEPT. OF AGRICULTURE



Patented

U. S. D.

Patented

U. S. D.

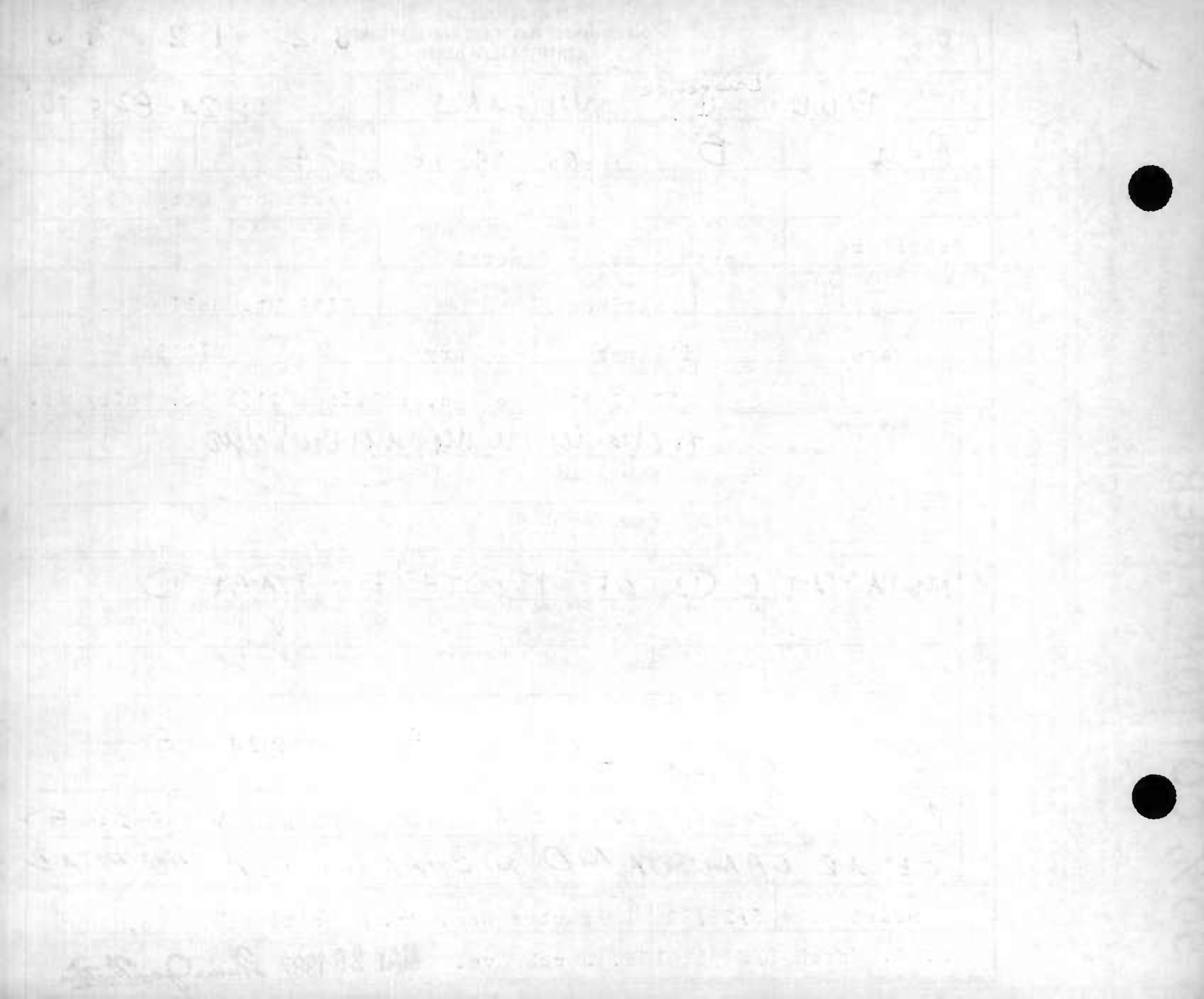
Patented

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 4 3 | |
|---|--|------------------------------|--|--|-------------------|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| PAUL LAWRENCE WILLIAMS | | | | | 05-24-82 | | | | | 5:10 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | B | | 05-09-16 | | 64 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | USA | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | North Charles General | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | | | |
| MD | | | | Baltimore | | 2151 Mt. Holly St. | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Edward Williams | | | | Mary Williams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | | | 217-07-5234 | | Bede B. Williams 2151 Mt. Holly St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably Pulmonary embolus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4151 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>METASTATIC CA OF PROSTATE - STAGE D</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>05-16</u> , 19 <u>82</u> , to <u>05-24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>05-24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| CESAR GAMBOA M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 5-24-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| CESAR GAMBOA, M.D. | | | | N. CHARLES GEN. HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 5/28/82 | | Arbutus Mem. Pk. | | Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | MAY 26 1982 | | James J. [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 4 4

REG. NO.

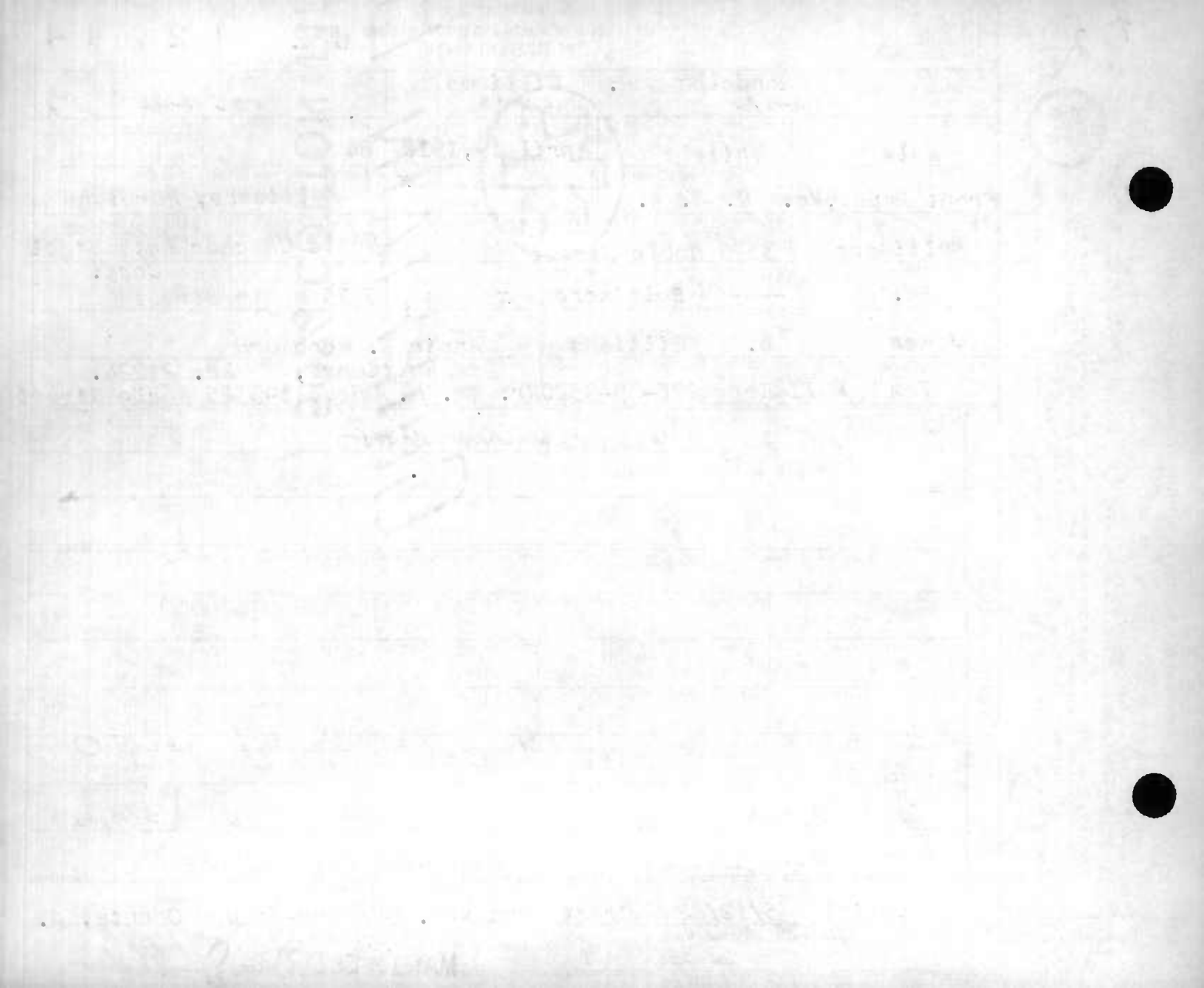
| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Randolph</i> MIDDLE <i>R.</i> LAST <i>Williams</i> <i>RANDOLPH WILLIAMS</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>05-10-82</i> | | 2b. HOUR <i>3⁵⁰ A M</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>April 19, 1918</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Front Royal, Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, Maryland MD</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3325 Noble Street</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Scale Checker</i> | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>----</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>James B. Williams</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie E. Woodward</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>WWII&Korea 226-09-9320</i> | | 17. INFORMANT ADDRESS <i>Baltimore, Md. 21224.</i> <i>Mr. Wm. L. Odewalt-3325 Noble Street</i> | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> <i>4275</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) this hospital attended the deceased from <i>5/19</i> , 19 <i>82</i> , to <i>5/10</i> , 19 <i>82</i> , that (b) (we) lost saw the deceased alive on <i>5/10</i> , 19 <i>82</i> , and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Gordon Raphael</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>5/10/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GORDON RAPHAEL</i> | | | | 22e. ADDRESS <i>BALTIMORE CITY HOSPITAL</i> | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5/12/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Crest Lawn Mem. Gardens-Howard County, Md.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <i>John H. Moran, Inc.</i> <i>3000 E. Baltimore St.</i> <i>Baltimore, Md. 21224</i> | | | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1982 <i>James J. VanNathan</i> | | | |

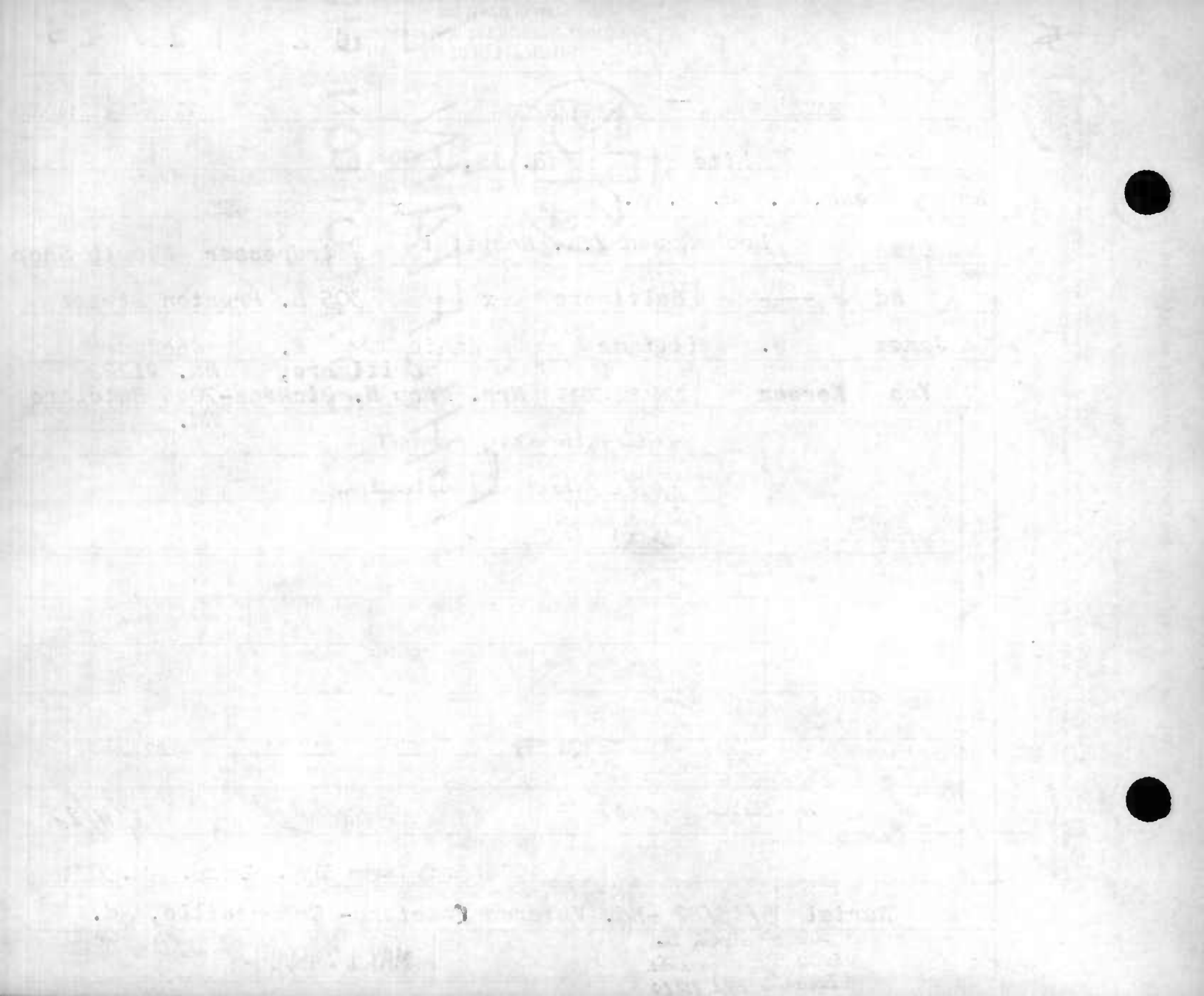


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 4 5 | | | | | |
|--|--|---|--|---|--|---|--|---|--|-----------------|--|--|--|------------|--|
| 1 - FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | | 2a DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | |
| RAYBURN -- WILLIAMS | | | | | | 5 | | 11 | | 82 | | 12:40AM | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| MALE | | White | | Feb. 18, 1929 | | 53 | | YRS. | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Happy Creek, Va. | | U. S. A. | | | | BALTIMORE CITY MD. | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS, OR INDUSTRY | | | | | | | |
| BALTIMORE | | Loch Raven V.A. Hospital | | | | Hairdresser | | Beauty Shop | | | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | | | |
| Md | | ---- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 305 E. Preston Street | | | | | | | |
| 14. FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| James B. Williams | | Annie E. Woodward | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | | |
| Yes | | Korean | | 226 36 5617 | | Baltimore, Md. 21222 | | Mrs. Mary H. Dickens-7044 Belclare Rd. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | | | | | | | | |
| 5860 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) <u>gastrointestinal bleeding</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) <u>renal failure</u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a I certify that (X) this hospital attended the deceased from <u>MARCH 29,</u> 19 <u>82</u> , to <u>MAY 11,</u> 19 <u>82</u> , that (X) (we) lost the deceased on <u>MAY 11,</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | | | | | | |
| Paul Muller M.D. | | | | 5/11/82 | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | | | |
| | | 3900 Loch Raven Blvd. Balto., Md. 21218 | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 5/13/82 | | Md. Veteran Cemetery | | | | Crownsville, Md. | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 25a DATE REC'D. BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | |
| John H. Moran, Inc. 3000 E. Baltimore St. Baltimore, Md. 21214 | | MAY 17 1982 | | | | [Signature] | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Person retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 2 7 4 6 | | |
|--|--|--|--|--|--|--|--|--|--|--|------------------|----------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) Rebecca - Williams | | | | | | | | | | MONTH DAY YEAR 5 16 82 | | 5:50 AM |
| 3 SEX Female | | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 10 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1358 Carroll Street | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Rufus Hines | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 900-39-1702 | | 17 INFORMANT ADDRESS Roosevelt Hines 2303 Ashburton St. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA 4360 DUE TO, OR AS A CONSEQUENCE OF (b) V-FIB Coronary Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) AORTIC STENOSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Primary Hypertension | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3/82 , 19 82 , to 5/16 , 19 82 . saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Philhoma DEGREE MD | | | | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RJ Williams | | | | | 22e. ADDRESS 4200 EDMONDSON AVE Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | ADDRESS 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE MAY 19 1982 Rose Jan. Mather | | | | | |

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 7 4 7
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------------|-------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RUTH E. Williams | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 8 1982 | | | | 2b. HOUR 0410A | |
| 3. SEX F | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 01 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of MD Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemp | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE MD | | 13b. COUNTY Balt city | | 13c. CITY OR TOWN Baltimore | | 13e. STREET ADDRESS 930 Brooks LA Apt 1A | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY CARROLL | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA HEURON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 167 004 | | 17. INFORMANT Name Address Howard Thomas 812 Lexington Apt 2 CHART | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESP. ARREST 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC OVARIAN CA DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <10 min | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Thrombocytopenia | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/28/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel OBSTRUCTION | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/27 1982 to 5/8 1982 , that (I) (we) first saw the deceased alive on 5/8 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE Scott K. Kertman MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 5/8/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT K. KERTMAN | | | | | | 22e. ADDRESS Univ. of MD Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave | | | | | | 25a. DATE REC'D BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

Handwritten notes on lined paper, including the date "May 2, 1964" and various illegible entries.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 7 4 8 | |
|--|--|---------------|---|--|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Theresa Williams | | | | | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 12 71 | | 6. AGE (IN YEARS LAST BIRTHDAY) 10 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fla. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD 5 15 1982 | | 2d. HOUR 1:45 | |
| 9a. BALTIMORE CITY OR COUNTY OF DEATH | | | Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2781 Tivoly Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2781 Tivoly Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James E. William | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deloris Brown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A | | | 16b. SOCIAL SECURITY NO. N/A | | | 17. INFORMANT Audrey Mitchell | | | ADDRESS Ft. Bragg, N.C. 400 Searight Dr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:20AM 5/15 1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) housefire | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2781 Tivoly Avenue, Baltimore City, MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE Margarita A. Korell | | | TITLE (SPECIFY) Assistant | | | M.D. MEDICAL EXAMINER | | | DATE SIGNED 5/15/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crestview Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cairo, Ga. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE | |

20% CUMULATIVE

THE M. D. D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8-2 1 2 7 4 9 | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| KRISTEN LEIGH WILLIS | | | | 5-5-82 | | | | 5:35P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | |
| Female | | White | | April 1, 1974 | | 8 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N. Carolina | | USA | | | | Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | John Hopkins Hospital | | | | Student | | --- | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| N. Carolina | | | | High Point | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3610 Rockwood Drive | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Jerry Willis | | | | Jane Ferguson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | None | | Sechrest Funeral Home, | | High Point, N.C. 27262 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>respiratory failure</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>diffuse interstitial pneumonia</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute lymphoblastic leukemia</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2/26/82 | | bone marrow transplant | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. LOCATION | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 3</i> 19 <i>82</i> , to <i>May 5</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>May 3</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| <i>Cecil Borel MD</i> | | | | | | | | <i>5/3/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| CECIL BOREL MD | | | | | | Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Removal | | 5/8/82 | | Floral Gardens | | High Point, N. C. STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | | MAY 6 1982 | | <i>James J. Nathan</i> | | | |

BP

5 05 22 00 1
JAN 19 1961
RECEIVED

RECEIVED JAN 19 1961

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

100-100000-100000
100-100000-100000
100-100000-100000

Item 23b g567 5/27/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 5 0

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM F. WILLIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 24 82 | | 2b. HOUR 1:40 PM |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY of MARYLAND | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. CITY OR TOWN BALTIMORE | 13c. STREET ADDRESS 2523 W. FAIRMOUNT AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WILLIS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MERTINA OWENS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKN.) Yes | | 16b. SOCIAL SECURITY NO. 219-10-1623 | | 17. INFORMANT ESTHER WILLIS ADDRESS 2523 W. FAIRMOUNT | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 2880 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) LEUKOPENIA | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 1 DAY 3 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Metastatic LARYNGEAL CARCINOMA | | | | | |
| 19a. DATE OF OPERATION 4/27/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Spinal Cord Compression | | 20a. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 26 1982 to MAY 24 1982 , that (I) (we) lost saw the deceased alive on MAY 24 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE David J. Jenkins | | DEGREE MD | | 22c. DATE SIGNED 5/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID J. JENKINS MD | | 22e. ADDRESS 22 S GREENE Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY md. Veteran Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

U.S. PATENT OFFICE

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 7 | 5 | 1 | | | |
|---|--|--|---|--|--|--|--|--|--|---|---|---|---|-----------------------------|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LUCAS W. WILSON | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 82 2b. HOUR 4:30 A.M. | | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1916 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. DEATON MEDICAL CENTER | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mechanic | | | 12b. KIND OF BUSINESS OR INDUSTRY Brooks Price | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Balto. Co. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 7341 Windsor Mill Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lucas White Wilson, Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Smiley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 578-14-8937 | | | 17. INFORMANT Mrs. Bertha Wilson 21207 7341 Windsor Mill Rd. Balto. MD. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4380 PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) 1971 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-19-82 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4380 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 82 , to 5-22 , 19 82 , that (I) (we) last saw the deceased alive on 5-21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE William Lamm MD DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 5-22-82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM LAMM MD | | | | | | | | | | 22e. ADDRESS UNIVERSITY MD HOSPITAL - FAM. MED DEPT | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-25-82 | | | 23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Balto. MD | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. BALTIMORE BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Francis J. Van Kester | | | | | | | | | | 8728 Liberty Road Randallstown, MD. 21133 MAY 25 1982 | | | | | | | | | |



Received of the
Cashier of the

of the
and
of the

of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the death certificate file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 5 2

REG. NO.

| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Jesse Winston | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-25-82 | | 2b. HOUR 3:40pm |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 6 2 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia USA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE md. | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 415 Edsall rd. Apt. F | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Winston | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen BANKS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 213-14-8014 | | 17. INFORMANT Tony Winston ADDRESS 712 E. 23rd St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, right lung with DUE TO, OR AS A CONSEQUENCE OF (b) cerebral metastases DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/6 , 19 82 , to 5/25 , 19 82 , that (I) (we) lost saw the deceased alive on 5/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Lillian D. Hicken | | DEGREE M.D. | | 22c. DATE SIGNED 5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. HICKEN, M.D. | | 22e. ADDRESS St Agnes Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY NewTown Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE HARRISONBURG VA. | | 24. FUNERAL DIRECTOR NAME ADDRESS Betts Funeral Home 1129 N. Caroline St. | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Thayer | | | |

2:40p 2-25-82

WEEK 13

Baltimore City

Baltimore St. James Hospital

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

1-2-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 through 6 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| #14,15, Film G571 9/8/82 kam | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 7 5 3 | |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) William Wise | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/17/82 | | 2b. HOUR 4:48 PM | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 12 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Columbia, S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY, GIVE STREET ADDRESS) SIDRA Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | |
| 14. FATHER'S NAME FIRST Irving MIDDLE William LAST Wise | | | | 15. MOTHER'S MAIDEN NAME FIRST Lydia MIDDLE Hamilton LAST DAVIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-10-5470 | | 16c. INFORMANT Mrs. Jean Frazier ADDRESS 2211 Windsor Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular Fib APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ASCD | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/17 8 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 82 , to 5/17 , 19 82 , that (I) (we) lost saw the deceased alive on 5/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE A. Enrique | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ENRIQUE MD | | 22e. ADDRESS SUITE 54 HOFFBERGER Bldg 24215 Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ ADDRESS 2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1982 REGISTRAR'S SIGNATURE Theresa J. North | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 2 7 5 4

FOR
1. STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|----------------------------|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD | | | FIRST WISNIEWSKI | | | LAST | | | 3a. DATE OF DEATH MONTH DAY YEAR 05-16-82 | | | | 7b. HOUR 2:10 PM | | |
| 1. SEX M | | | 4. RACE W | | | 5. DATE OF BIRTH MONTH DAY YEAR 09 13 24 | | | 6. AGE IN YEARS (LAST BIRTHDAY) 57 | | | 8. UNDER 1 YEAR MONTHS DAYS | | 9. UNDER 24 HRS. HOUR MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 1. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION City Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drucklayer | | | 12b. KIND OF BUSINESS OR INDUSTRY Comco | | | | | | |
| 13a. STATE MD | | | 13b. COUNTY Ches. | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS 422 Chino St. | | | | | | |
| 14. FATHER'S NAME John | | | 15. MOTHER'S MAIDEN NAME Sophia Rockwiska | | | | | | | | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) Yes (IF YES, GIVE WAR OR DATE) WW II | | | 16b. SOCIAL SECURITY NO. 216-18-4976 | | | 17. INFORMANT ADDRESS Henry Wisniewski 231 S. Collington | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 5339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Peptic ulcer disease DUE TO, OR AS A CONSEQUENCE OF (c) intercostal neuralgia | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) intercostal neuralgia | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-16-82 , 19__, to 5-16-82 , 19__, that (I) (we) last saw the deceased alive on 5-16-82 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Jules C monier MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 5-16-82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules C monier MD | | | 22e. ADDRESS Baltimore City Hospitals | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5.21.82 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Raymond L. Karsowski | | | ADDRESS 25 S. 1st St. | | | 25a. DATE REC'D BY REGISTRAR MAY 20 1982 | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | | |

MEDICAL CERTIFICATION

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy must be performed.

| STATE OF MARYLAND | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 2 7 5 5 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK J. WISNIEWSKI (WESNEWSKI) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 2 1982 | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 - 24 - 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1412 ANDRE ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman | | 12b. KIND OF BUSINESS OR INDUSTRY Water Front | |
| 13a. STATE MARYLAND | | 13b. COUNTY — | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1412 Andre ST. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Theodore Wisniewski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Rutkowski | | | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-7365 | | 17. INFORMANT ADDRESS Miriam Ludmitzke 526 E. Clement ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ischemic myocardiopathy 4148 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 82 , to May , 19 82 , that (I) (we) last saw the deceased alive on April , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Eugenio E Benitez MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 5/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENIO E BENITEZ MD | | | | | | 22e. ADDRESS 3455 WILKENS AVE Balto Md 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 5/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME Charles L. Stevens Funeral Home Inc. | | | | | | ADDRESS 154 E. Fort Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 4 1982 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Ami Q. Z... | | | |

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a detailed account of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a detailed account of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a detailed account of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a detailed account of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a detailed account of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a detailed account of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a detailed account of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a detailed account of the work done during the year.

1 - STATE REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|--|--|------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hattie - Witherspoon</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5-20-82</i> | | 2b. HOUR <i>5:50 P.M.</i> | | |
| 3. SEX <i>F</i> | | 4. RACE <i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>02-02-14</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>68</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>SC</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>US</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SBGH 3001 S. Hanover St.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>MD</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>1436 Ward St, Balto.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Meyers</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mammie (Mimmie Gemmerson)</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>0</i> | | 16b. SOCIAL SECURITY NO. <i>---</i> | |
| 17. INFORMANT <i>Olga Meléndez</i> | | 18. ADDRESS <i>3001 S. Hanover St</i> | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio-respiratory arrest, 5/20/82</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metabolic Acidosis, Lung CA.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2762</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Congestive Heart Failure, Atro-Ventricular Dislocation</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-13</i> , 19 <i>82</i> , to <i>5-20</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5-20</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Olga Meléndez</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>5/20/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Olga Meléndez</i> | | 22e. ADDRESS <i>3001 S. Hanover St</i> | | | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5/26/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem Pk</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Kenneth H. Law Funeral Home 4611 Park Hets</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 24 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>James J. Hunter</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

NEW

10

14

NEW

NEW

NEW

NEW

NEW

NEW

13

NEW

NEW

NEW

NEW

NEW

NEW

NEW

NEW

NEW

NEW

NEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Herman F. Witkowski, Sr. | | | | | | | | 5 22 82 | | 7:15 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN. | |
| Male. | | White | | 4 2 14 | | 68 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| USA. Ohio | | USA | | | | Balto. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | South Balto General Hospital | | | | | | Retired | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | | | 3627 Pobski Highway | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Alex - Witkowski | | IDA - Grabowski | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | WW II | | Mrs. Mary Witkowski, same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia & gen. peritonitis</i> 5570 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Defaction, Sen. bowel</i> (c) <i>Mesenteric thrombosis</i> | | | | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>s/p. Mesenteric Thrombosis; atheros. coronary art. heart</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/21/82</u> , 19 <u>82</u> , to <u>5/22/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/22/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <i>Santayana</i> | | DEGREE | | 22c. DATE SIGNED 5/22/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| SANTAYANA | | 1022 Charing Norton Ct. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 5/25/82 | | Gardens of Faith | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE REC'D. BY REGISTRAR | | 25a. REGISTRAR'S SIGNATURE | | | | | | | |
| Joseph N. Zannino, 263 S. Conkling St. | | MAY 25 1982 | | <i>Thomas J. Zannino</i> | | | | | | | |



1940

Joseph A. Cannino, 223 S. Locust St.
Philadelphia, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 5 8

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William H. Witzke Jr. William H. Witzke | | 2a. DATE OF DEATH MONTH 5-20-82 8-5-20-82 | | 2b. HOUR 6 5/4 M | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 11-3-27 11-3-27 | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | 9. CITIZEN OF WHAT COUNTRY? USA | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Denton Med Ctr | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY Valspar Corp. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 1344 Meridene Drive 1344 Meridene Dr. 21239 | | |
| 14. FATHER'S NAME William H. Witzke | 15. MOTHER'S MAIDEN NAME Edna Pierpont | 16. ADDRESS Pierpont | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. 216-20-1587 | 17. INFORMANT Carolyn Witzke (wife) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5712 IMMEDIATE CAUSE (a) <u>Cerebralosis of liver & ascites</u> DUE TO, OR AS A CONSEQUENCE OF, <u>Alcoholism</u> (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alcoholism</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> 19 <u>82</u> to <u>May 20</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>May 20</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Julian W. Reed</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN W. REED M.D. | | 22e. ADDRESS 511 S. CHAS ST 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5/24/82 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL HOME NAME Schimmunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1982 | | | |

100-23-200

112

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

100-23-200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 7 5 9 | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| CECELIA WOLK | | FEMALE | | WHITE | |
| 2a. DATE OF DEATH MONTH DAY YEAR | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MONDAY, MAY 24, 1982 | | JANUARY 1, 1898 | | 84 | |
| 7b. HOUR | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 7:15A _M | | | | BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| BALTIMORE | | 6317 PARK HEIGHTS AVE. APT. 518 (21215) | | HOUSEWIFE | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | | | BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| MAX BERKOW | | EVA UNKNOWN | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus-Metastatic</i> <i>1509</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Obstructive Uropathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Disease</i> | |
| 215-46-8448 | | MR. LeROY WOLK | | 4 MOS. 2 MOS. | |
| 6711 PARK HTS. AVE., APT. 416 #21215 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Hypertensive Cardiovascular Disease</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>6-2</i> , 19 <i>81</i> , to <i>5-24</i> , 19 <i>82</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>4-28</i> , 19 <i>82</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did not)</i> view the body after death. | | | | | |
| 22b. SIGNATURE <i>Barnett Berman, M.D.</i> | | DEGREE | | 22c. DATE SIGNED <i>5-24-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DR. BARNETT BERMAN | | 611 PARK AVE. (21204) | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 5-25-82 | | ANSHE EMUNAH (AITZ CHAIM) | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS. 6010 REISTE RSTOWN RD. BALTIMORE, MD. (21215) | | MAY 28 1982 | | <i>James J. North</i> | |

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

| | | | | | | | | | |
|------|------|------|------|------|------|------|------|------|------|
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE A FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 7 6 0 | |
|--|--|------------------|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNADETTE A K A BERNETTE WOOD | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 15 19 82 | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 11, 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 33 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 16 19 82 | | 2b. HOUR 10:50 a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4933 Todd Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SWITCHBOARD OP. | | 12b. KIND OF BUSINESS OR INDUSTRY MORGAN STATE | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4933 TODD AVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RODDIE F. WOOD JR. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY TURNER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215-46-6352 | | 17. INFORMANT ADDRESS MRS DOROTHY WOOD 1519 N. CAREY ST | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH ? P.M. 5-15- 19 82 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Hanged self. | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4933 Todd Ave. Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER DATE SIGNED 5-17-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY WESTERN STAR CEM | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALTO CO MD | |
| 24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 | | | | | |
| ADDRESS 2132 W. NORTH AVE | | | | | | 25b. REGISTRAR'S SIGNATURE Thomas J. Heston | | | | | |

10/10/1941 8:15 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 6 1 REG. NO. | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward C Wooden | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 16 82 | | | 2b. HOUR 7:00 PM | | | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 8 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Trouident Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 308 N. Pulaski St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AARON Wooden | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA Wooden | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. 212-10-1128 | | 17. INFORMANT ADDRESS Sidney H. Tinley, III 2112 Woodfork Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. Rashdan | | | | | | DEGREE | | 22c. DATE SIGNED 5/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.A. RASHDAN | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO Maryland | | | |
| 24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS | | | | | | ADDRESS 1701 LAURENS | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 | | REGISTRAR'S SIGNATURE James A. Morton | |

10-1-10

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Signature]



[Faint, mostly illegible text, possibly a continuation of the letter or a separate document.]

Very respectfully,
J. H. [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12762 | |
|---|----------------------|---|--|--|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANDREW F. WOODLAND | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 5-6-82 | | 2b. HOUR 5:07A | | | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 44 | 6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS. | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | 7c. DATE PRONOUNCED DEAD 5-6-82 | 2d. HOUR 5:07A | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1737 Pennsylvania Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4018 Annellen Road | | | |
| 14. FATHER'S NAME FIRST William MIDDLE F. LAST Woodland | | | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Smith LAST Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-42-4647 | | 17. INFORMANT ADDRESS Nancy L. Woodland 4018 Annellen Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY 4:55AM 5-6-82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | | 21f. LOCATION STREET 1737 Pennsylvania Avenue CITY OR TOWN Balto., Md. COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) Assistant | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | M. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 5-6-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Park | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Co. STATE MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE Francis Santhorne | | | | | |

5098



1881
1882
1883
1884
1885
1886
1887
1888
1889
1890
1891
1892
1893
1894
1895
1896
1897
1898
1899
1900

SECTION 1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the death certificate is filed in the funeral director's office, it should be detached for use as the burial-transit permit. Then please remove carbon patient's page 2 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 6 3

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Aretha Woodrum | | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-82 | | 2b. HOUR 4:39pm | |
| 3. SEX Female | | 4. RACE NEGROID | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1967 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 15 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 15 | | IF UNDER 24 HRS. HOURS MIN. 4:39pm | |
| 7a. BIRTHPLACE (COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. CITY OR TOWN OF DEATH Balto. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 219 N. Milton Ave. | | 13f. STREET ADDRESS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Purcell Woodrum | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Goode | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16a. SOCIAL SECURITY NO. 215-74-1278 | | 17. INFORMANT Lillian Goode | | 17. ADDRESS 219 N. Milton | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) gram negative sepsis DUE TO, OR AS A CONSEQUENCE OF (c) chronic liver failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unmed. | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) peritonitis | |
| 19a. DATE OF OPERATION 5/12 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED peritonitis | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I (this hospital) attended the deceased from 5/4 , 19 82 , to 5/12 , 19 82 , that (I) (we) last saw the deceased alive on 5/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE John T. Farney MD | |
| 22c. DATE SIGNED 5/12/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Farney, MD | | 22e. ADDRESS Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD. | | 24. FUNERAL DIRECTOR NAME Calvin B. SCRUGGS | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1982 | |
| 25b. REGISTRAR'S SIGNATURE James J. Martin | | 25c. ADDRESS 1412 E. Preston St. | | 25d. DATE REC'D. BY REGISTRAR MAY 13 1982 | |

BP

DHMH-16 50M 1/81
(VRA 15, 4)

des :

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 6 4

REG. NO.

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Lillyan May Woods | | 2a. DATE OF DEATH MONTH DAY YEAR 5 4 82 | | 2b. HOUR 8:42 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 05 23 96 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S. USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE md | | 13b. COUNTY - | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John O. Frederick | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Sindall | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. 217 01 6591 | | 17. INFORMANT ADDRESS Randallstown, Md Charles W. Frederick 3835 Elmeroft Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 4300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } (b) subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-28 , 19 82 , to 5-4 , 19 82 that (I) (we) last saw the deceased alive on 5-3 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Lee Ann Roberts, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 5-4-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lee Ann Roberts, M.D. | | 22e. ADDRESS Sinai Hospital Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore | | 24. FUNERAL DIRECTOR Burgess Funeral Home ADDRESS 3631 Falls Road 21211 | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE Charles W. Frederick | | | |



female

white

52

annexation

USA

xx

House

altiora

referred

July

1911

born

no

21 of 1911

Charles

Frederick 1885

Marshalltown, Iowa

X

trial

5/7/12

1700 of 1911

altiora

James Marshall House 301 Alta Road 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 6 5
REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Viola Woods</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>05/16/82</i> | | 2b. HOUR <i>12:20 PM</i> | |
| 3. SEX <i>Female</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>09-08-00</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>City</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Luteral Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>MD</i> | 13b. COUNTY | 13c. CITY OR TOWN <i>Balto.</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>2652 Lanthan Ave</i> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>220206619C1-ftorable</i> | | 17. INFORMANT ADDRESS <i>2652 Lanthan Ave</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> <i>2506</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.U.A. & C.A.F.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>D.M.</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>A. gangrene of toe Rt</i> | | | | | |
| 19a. DATE OF OPERATION <i>5/4/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gangrene of toe Rt</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/16/82</i> to <i>5/16/82</i> , that (I) (we) last saw the deceased alive on <i>5/16/82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Charles A. Rice</i> | | DEGREE | | 22c. DATE SIGNED <i>5/16/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles A. Rice</i> | | 22e. ADDRESS <i>7300 Ashburton Ave. MD</i> | | 22f. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5/21/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Maryland Nat. Park</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore H.O. County MD.</i> | | 23e. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME <i>Charles A. Rice FSPA</i> | | 1300 Eutaw Place | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 20 1982</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles A. Rice</i> | | 25c. REGISTRAR'S SIGNATURE | | | |

00151 30

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

CO. 9

1910



U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 7 6 6 REG. NO. | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bee Woodson | | | | 2a. DATE OF DEATH May 31, 1982 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH 1 MONTH 10 DAY 15 YRS. | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1300 E. Lanvale St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Willie Woodson | | 15. MOTHER'S MAIDEN NAME Lillie Bird Mayo | | 13e. STREET ADDRESS 1300 E. Lanvale St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Leon Woodson Rt. 1 Box 131, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1659 IMMEDIATE CAUSE (a) Large cell undifferentiated carcinoma of left lung, 3 mos. with metastases. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 82 , to May 20, 1982 , that (I) (we) lost saw the deceased alive on May 20, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) F.S. Leacock, M.D., P.A. | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6/1/82 | |
| 22d. ADDRESS 3502 W. Rogers Avenue, 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Mitchell | | 23d. LOCATION CITY OR TOWN COUNTY STATE Keysville VA | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 James J. Martin | | | |

SECTION 10

WATER



JUN 2 1965
JAMES J. WILSON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 7 6 7
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael L. Woodward, Jr. | | | 2a. DATE OF DEATH MONTH 5 DAY 31 YEAR 82 2b. HOUR 11:58 PM | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 70 | 6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS. | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST Michael MIDDLE L. LAST Woodward, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST Diane MIDDLE LAST Weathers | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. NA | | 17. INFORMANT NAME Michael Woodward Sr. ADDRESS 3103 Garrison Blvd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 2840 DUE TO, OR AS A CONSEQUENCE OF (b) Fanconi's Aplastic Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Hemochromatosis (Diabetes Mellitus, Adrenal Insufficiency, Concomitant) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 4 years 1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fanconi's Aplastic Anemia; Hemochromatosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) this hospital attended the deceased from July/September/80 to May 19 82 , that (ii) I saw the deceased alive on May 30 19 82 , and that in my (a) opinion death occurred on the date and hour and from the causes stated above, (b) yes (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Daniel E. Walloch, MD | | DEGREE Private Pediatrician | | 22c. DATE SIGNED 5/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel E. Walloch, MD | | 22e. ADDRESS 19 Walker Ave., Suite 200 Baltimore, Md. 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Ch. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0 - 15.10.5

Mr. J. H. ... (7) ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

Mr. J. H. ... 1/30 ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Darhl Gerald Woolford | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 11 1982 | | | 2b. HOUR 2:50 a. M. | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9 14 59 | 6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD 5 11 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) front of 607 N. Augusta Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Seaman | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 4247 Rokeby Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Merrick Woolford | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-70-7603 | | | 17. INFORMANT ADDRESS Sylvia Woolford 4247 Rokeby Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of left chest and Neck 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR ? P.M. 5 11 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was stabbed | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 607 N. Augusta Ave., Baltimore, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 5-11-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Family Lot | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salem, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS LERROY O. DYETT 4600 LIBERTY HGTS. AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

15788

15788

20% COTTON

15788

15788

15788

15788

15788

15788

15788

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be called before burial or removal.

| film 569 item Part2 21e-2ff STATE OF MARYLAND | | | | | | | | | | |
|--|--|---|--|---|---|---|------------------------------------|--|--|------------------------------|
| 1. FOR STATE REGISTRAR 7-12-82 cn DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 7 6 9 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DOCELYN W ORLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/17/82 | | | | | 2b. HOUR 6:05 P.M. |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 3 1964 | | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4128 Reisterstown Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mack Connor | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elena Talbott | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Elena Talbott 4128 Reisterstown Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPOXIA DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BY NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I). Apparent Hypodermic Injection (Heroin) in left antecubital fossa one week prior to admission; severe synergistic gangrene of left arm, shoulder and anterior chest resulted causing sepsis | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/15/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SEPSIS OF LEFT ARM | | 19c. IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) HYPODERMIC INJECTION IN LEFT ARM | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Not known | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE not known | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15/82 19 82 , to 5/17 19 82 , that (I) (we) last saw the deceased alive on 5-17 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dawn R. Gens | | | | | DEGREE MD | | 22c. DATE SIGNED 5/17/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dawn R. Gens | | | | | 22e. ADDRESS Micmss | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C. Brown Comm. F/H 1206-08 W. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1982 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE James J. Kistner | | | | | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

100-35444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 35

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 7 7 0 REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Gertrude Wrayman | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 13 82 | | | 2b. HOUR M | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 9 42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1012 N. Eden St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1012 N. Eden St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Lillie Jackson 1012 N. Eden St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MIN. 30 MIN. 20 YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 19 81 to MAY 19 82 , that (I) (we) last saw the deceased alive on MARCH 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Lee R. Barker | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5/13/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEE R. BARKER | | | | | 22e. ADDRESS BALTO. CITY HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE MAY 17 1982 Frances Jean Nathan | | | | |

2001 71 YAMA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 7 | 7 | 1 |
|--|--|--|---|--|---|--|---|--|---|---|-----------------------------------|-----------------------------|---|-----------------------------|---|---|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE V. LAST WRIGHT | | | | | | | | | | 2a. DATE OF DEATH MONTH MAY DAY 18, YEAR 1982 | | | | 2b. HOUR 10:30A M | | |
| 3. SEX FEMALE | | | 4. RACE NEGRO | | | 5. DATE OF BIRTH MONTH 3 DAY 12 YEAR 91 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR COUNTY) MD HANCOCK CO | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN NURSING HOME, GIVE STREET ADDRESS) 715 West Lanvale Street | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | | | |
| 13a. STATE MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 715 W LANVALE | | | | | |
| 14. FATHER'S NAME FIRST William MIDDLE Wright LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE PEARSON LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS ROLAND WRIGHT III PARK AVE ANN 1114 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LIVER 1552 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from MARCH 1982, to MAY 12 1982, that (X) (we) lost saw the deceased alive on MAY 12 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated (X) (we) (did not view the body after death). | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED May 19, 1982 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH GANEY, M.D. | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 5-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY Acacurus | | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY MD STATE | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | 24b. DATE REC'D. BY REGISTRAR MAY 20 1982 | | | 24c. REGISTRAR'S SIGNATURE | | | | | | | | | | |

1571

DATE: MAY 11, 1962

TO: Baltimore City

FROM: Baltimore City

SUBJECT: [illegible]

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12772 | |
|---|-------------------------|--|---|---|---|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Raymond O. Wyatt | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 2 YEAR 1982 | | 2b. HOUR 5:34 AM <input type="checkbox"/> | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 3 DAY 19 YEAR 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7c. DATE PRONOUNCED DEAD MONTH 5 DAY 2 YEAR 1982 | | 7d. HOUR 5:34 AM <input type="checkbox"/> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance - Sea Breeze Inn | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 94 Kinship Road | | | |
| 14. FATHER'S NAME FIRST Philmore MIDDLE Wyatt LAST Wyatt | | | | 15. MOTHER'S MAIDEN NAME FIRST Lucindy MIDDLE Long LAST Long | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 242-12-5820 | | 17. INFORMANT ADDRESS LaVoyce L. Dickerson - Balto. MD 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 5-2-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | 7922 Wise Avenue, Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 7 7 3 | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANKLIN | | | | MIDDLE (YANCY) YANCEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 10 82 | | 2b. HOUR 4.35 AM | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 23 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Edgemoor, MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1931 Ridgehill Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harrison Yancey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sidonia Reynolds | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 705-12-1857 | | 17. INFORMANT Amanda Lee | | ADDRESS 1931 Ridgehill Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 2396 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adult Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>intra-aortic aneurysm</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 5/10/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>M.A. Rashad</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.A. RASHAD AN | | | | 22e. ADDRESS 1101 E. North Ave. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY MD. VET. CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. | | | | ADDRESS 1101 E. North Ave. | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i> | | | |

Item # g567 5/26/82 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 2 7 7 4

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jocelyn BG Yancey | | 2a. DATE OF DEATH MONTH DAY YEAR 4 6 82 | | 2b. HOUR 425 M |
| 3 SEX Female | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR 4 6 82 | 6 AGE (IN YEARS LAST BIRTHDAY) 4 hrs YRS. | IF UNDER 1 YEAR MONTHS DAYS 4 2 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore City | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) — | 12b KIND OF BUSINESS OR INDUSTRY — |
| 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS Baltimore City Hospital |
| 14 FATHER'S NAME FIRST MIDDLE LAST Yancey Jocelyn Yancey | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yancey | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. — | | 17 INFORMANT ADDRESS — |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7689 Prematurity DUE TO, OR AS A CONSEQUENCE OF: Asphyxia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

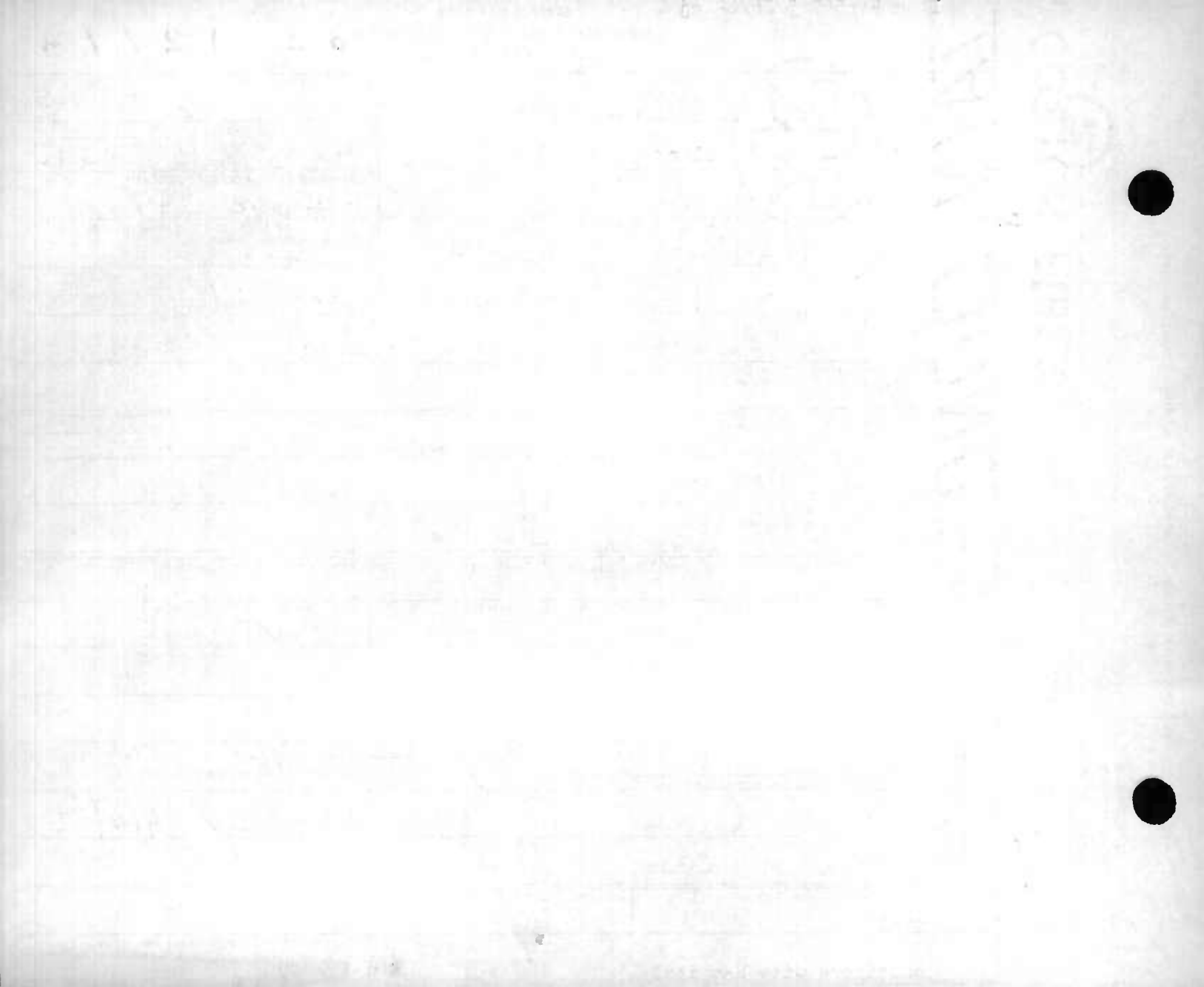
| | | | |
|--|---|--|---|
| 19a DATE OF OPERATION 4/16/82 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED — | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | 21f LOCATION STREET CITY OR TOWN COUNTY STATE — Baltimore City | |
| 22a I certify that (I) (this hospital) attended the deceased from 4/16 , 19 82 , to 4/6 , 19 82 , that (I) (we) lost saw the deceased alive on 4/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE D. Brewster-Lee | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED 4/6/82 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) D. Brewster-Lee | | 22e ADDRESS Baltimore City Hospital | |

| | | | |
|---|----------------------|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b DATE — | 23c NAME OF CEMETERY OR CREMATORY — | 23d LOCATION CITY OR TOWN COUNTY STATE — Baltimore City |
| 24 FUNERAL DIRECTOR NAME Baltimore City Hospital | | 25 DATE REC'D. BY REGISTRAR 21224 MAY 12 1982 | 25b REGISTRAR'S SIGNATURE — |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|--|--|---|-------------------------------------|--|--|----------|
| 1- STATE REGISTRAR | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 1 2 7 5 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR |
| MARSHALL T. YEIDER JR. | | | | | 5 3 82 | | | | | 8:05P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| MALE | | WHITE | | 10 15 95 | | 86 | | MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. IF UNDER 24 HRS. | | |
| Maryland | | USA | | | | BALTIMORE CITY | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | VAMC LOCH RAVEN, BALTO., MD. | | | | Retired Miner | | Coal | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2229 Bank St. | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| George W. Yeider | | | | | Sara Middleton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| Yes | | | | | War I | | 214 01 7644 | | | |
| | | | | | | | Marshall J. Yeider | | | |
| | | | | | | | James M. Yeider, Baltimore, Md. Son | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | | |
| 7 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxia</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure, Heart disease</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>APRIL 18, 19 82</u> to <u>MAY 3, 19 82</u> that (X) (we) last saw the deceased alive on <u>MAY 3, 19 82</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, mark with an X.) | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | |
| David Katz MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| DAVID KATZ | | | | | 3900 Loch Raven Blvd Balto., Md. 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | | |
| Burial | | May 7, 1982 | | Rocky Gap Cemetery | | Near Flintstone, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| NAME James F. Scarpelli, Cumberland, Md. | | | | | MAY 10 1982 | | | | | |



January

1962

John F. Kennedy

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

| Item 18c Film 574 12-8-82cn STATE OF MARYLAND | | | | | | | | | |
|--|--|---|-----------------------------|---|---|--|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 7 7 6 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Raymond A. YIENGER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 6-5-82 10 P M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7-28-1977 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. XXXXXX | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Curtis Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent- | | 12b. KIND OF BUSINESS OR INDUSTRY Raymond Inter. | |
| 13a. STREET ADDRESS 730 Camberley Circle | | | | | 13b. STREET ADDRESS XXXXXX XXXXXXXXXXXXXXXX | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Yienger | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Gies | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1 | | 17. INFORMANT ADDRESS Kathryn D. Yienger, Same As #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 5601 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonia (c) Ileus | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) A.S.C.U.D. | | | | | | | | | |
| 19a. DATE OF OPERATION 5/16 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7300 Ashburton Ave Baltimore, Maryland | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16 , 19 82 , to 5/16 , 19 82 , that (I) (we) last saw the deceased alive on 5/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Chad J. Pant | | | | | DEGREE Physician | | | 22c. DATE SIGNED 5/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chad J. Pant | | | | | 22e. ADDRESS 7300 Ashburton Ave | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE 1050 York Rd. Towson, Md. 21204 MAY 19 1987 | | | | |

0 1 1 1 0

90/10

100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

100/100 100/100 100/100 100/100 100/100

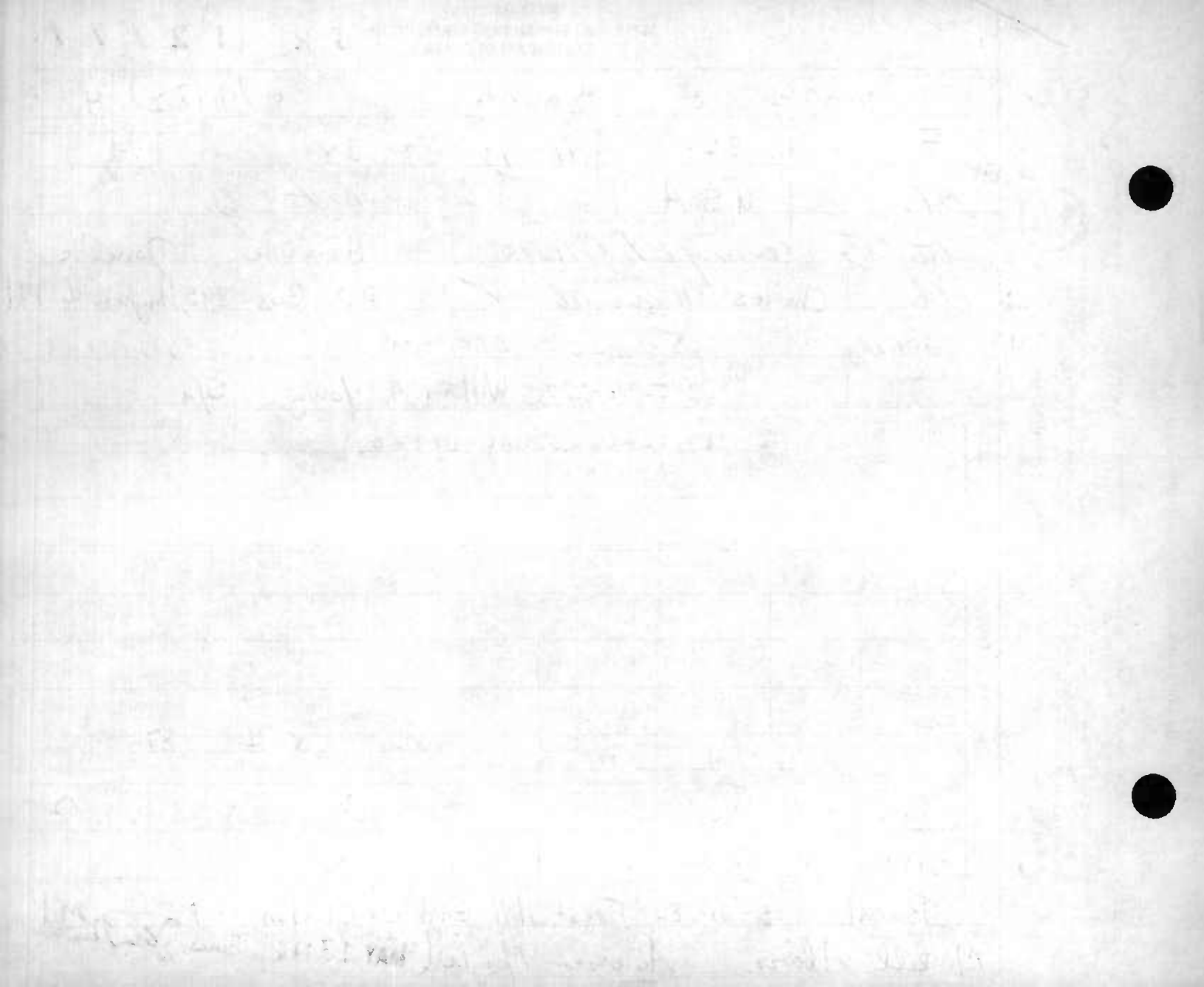
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 7 7 7 | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MARC E YOUNG | | 5/4/82 | | 4:12 P.M. | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7b. HOUR | |
| F | BL. | 11/13/43 | 38 YRS | 4:12 P.M. | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD | U.S.A. | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore City | Levinson MD MIEMSS | | Housewife | | Domestic |
| 13a. STATE | 13b. CITY OR TOWN | 13c. STREET ADDRESS | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| MD | Charles Hughesville | P.O. Box 395, Hughesville Md | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| JOHN | ELEANOR | 16b. SOCIAL SECURITY NO. 215-46-0275 | | | |
| | | 17. INFORMANT ADDRESS William A. Young S/A | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL BLEED 4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3/1982 to 5/4/1982, that (I) (we) last saw the deceased alive on 5/4/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE David R. Gens | | 22c. DATE SIGNED 5/4/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5-11-82 | | Forest Hill Gardens | |
| 24. FUNERAL DIRECTOR NAME | | 25. ADDRESS | | 26. DATE REC'D. BY REGISTRAR | |
| Marshall Adams | | Aguasco Maryland | | MAY 13 1982 | |



BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

item 1 #G567 5/14/82 ph

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 7 7 8

| | | | | | | | | | |
|---|-------------------------|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Noah - Nora A. Young, Jr | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 7 1982 | | | 2b. HOUR M 11:50 P | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 3 18 1951 | 6. AGE (IN YEARS) LAST BIRTHDAY 31 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 7 1982 | | | 7d. HOUR M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2200 Bk. Round Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1106 Shellbanks Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Noah A. Young, Sr | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona McCoy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Gladys Wheeler 805 Wilbert Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR 11:47 P.M. MONTH DAY YEAR 5 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2200 Bk. Round Rd. Balto. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | TITLE (SPECIFY) Deputy Chief | | | MEDICAL EXAMINER | | DATE SIGNED 5/8/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co Md | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. Nathan | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

25% COTTON BLEND

100% COTTON BLEND

100% COTTON BLEND

100% COTTON BLEND

100% COTTON BLEND

100% COTTON BLEND

100% COTTON BLEND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12779

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Timothy John Young | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 11 1982 | | | 2b. HOUR M 9:32 a. | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 16, 1956 | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 11 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2028 Mt. Royal Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1232 Sherwood Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Robert Young | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M. Rose Holmes | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-68-2280 | | 17. INFORMANT ADDRESS Mrs. M. Rose Young 1004 F Woodson Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:30xx 5 11 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject touched electrical wire | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roof | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2028 Mt. Royal Avenue, Baltimore, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 5-11-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1982 | |
| 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | | | | |

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

RECEIVED
JUN 16 1970

John

June 16, 1970

U.S.A.

Washington

Washington

1110 New York Ave.

Washington

Washington

John

John

John

John

John

John

Mr. J. Lee Young 1001 E. Woodson St.

917-62-2880

Washington, D.C.

Washington, D.C.

5/17/82

United

1001 E. Woodson St.

Washington, D.C.

Leonard J. Rock, Inc.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 2 7 8 0

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) AGNES | | | FIRST MIDDLE LAST YOUNGER | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1982 | | | 2b. HOUR 9:15 P.M. | | |
| 3. SEX Female | | | 4. RACE Negroid | | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 1, 1900 | | | 6. AGE IN YEARS LAST BIRTHDAY 82 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | | |
| 10. CITY OR TOWN OF DEATH BALTO, MD | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24 W. Franklin St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN Balto. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nathan Gaines | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAG ? | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 214-18-8617 | | |
| 17. INFORMANT ADDRESS Odelia Pete 2806 Garrison Blvd | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus. 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Peripheral vascular disease. (c) ADDV. / HBP. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 , 19 81 , to 5 , 19 82 , that (I) (we) lost saw the deceased alive on 4/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE Marianne LaFever DEGREE | | | 22c. DATE SIGNED 5/4/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIANNE LA FEVER | | | 22e. ADDRESS 1211 Wall St. Balto, Md. 21230 | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-7-82 | | |
| 23c. NAME OF CEMETERY OR CREMATORY My Auburn Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD. | | | 24. FUNERAL DIRECTOR NAME Calvin B. Scruggs Sr. ADDRESS 1412 E. Preston St. | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 | | |
| 25b. REGISTRAR'S SIGNATURE Jan Nathan | | | | | | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

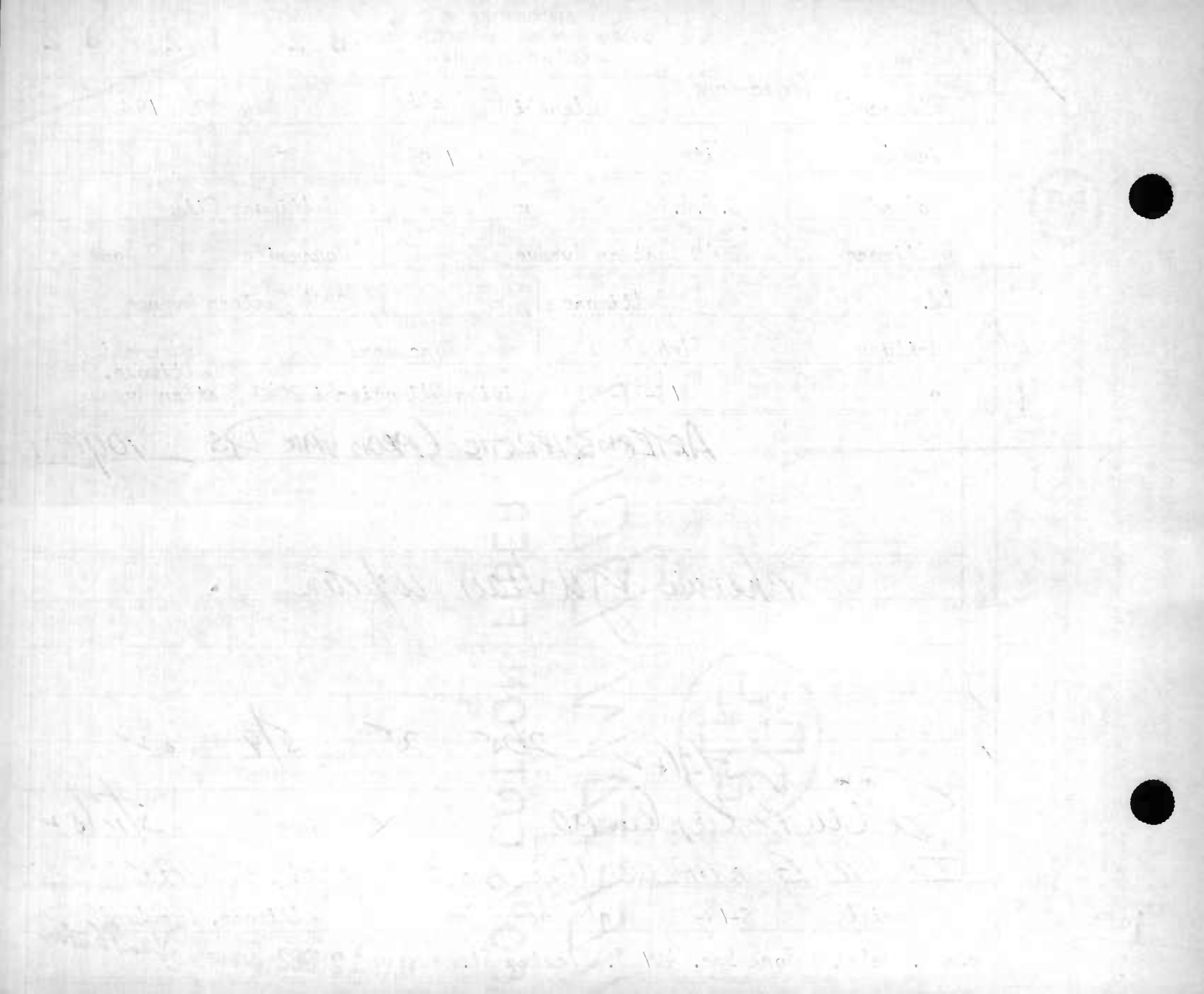
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be indicated here).

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA YOURKOVSKY | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1982 | | 2b. HOUR 6:00 AM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR UNKNOWN | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 69 | | 8. IF UNDER 24 HRS. HOURS MIN. 00 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3804 FORDLEIGH RD., APT. C | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | #21215 | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3804 FORDLEIGH RD., APT. C | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GERSON YOURKOVSKY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-44-1682T | | 17. INFORMANT HEBREW BURIAL SOC. SERVICE SOC. 1330 REISTERSTOWN RD., ATT'N: LEONARD GREEN- | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Disease 4149 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | BAUM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-4 hrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27 , 19 82 , to 5/29 , 19 82 , that (I) (we) lost saw the deceased alive on 5/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Sol Smith | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/29/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL Smith | | | | 22e. ADDRESS 6810 Park Hg Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 6-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CONG | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE | | | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i> | | | | | |

10

2nd year

| FOR 1 - STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 7 8 2 | |
|--|--|--|---|--|-----------------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mircella (Marcyanna) Zalenski (Zaleski) | | May 9 1982 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | June 2 1896 | 85 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Poland | U.S.A. | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 2040 Eastern Avenue | | Housewife | | Home |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Md. | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2224 Eastern Avenue |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Anthony Slezak | | Marcyanna Rudzewski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 215-28-9992 | | Baltimore, Md | |
| | | Vivian Glinowiecki | | 2040 Eastern Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4292 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASC DIS | | | | 10 years | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| Chronic Ju Stach infection | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| | | | | 21g. I certify that (I) (this hospital) attended the deceased from 2/25 19 25 to 5/9 19 82, that (I) (we) lost saw the deceased alive on 5/9 19 82, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated | |
| 21h. SIGNATURE | | DEGREE | | 21i. DATE SIGNED | |
| Trevor B. Kaplan MD | | | | 5/11/82 | |
| 21j. PHYSICIAN'S NAME (TYPE OR PRINT) | | 21k. ADDRESS | | | |
| TREVOR B. KAPLAN MD | | 129 S. BROADWAY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5-13-82 | | Holy Rosary Cem | |
| | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| | | Baltimore, Maryland | | MAY 12 1982 | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John M. Weber & Sons Inc. 401 S. Chester St. | | | | Frances Santhorn | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. It may be retained by the hospital or attending physician.

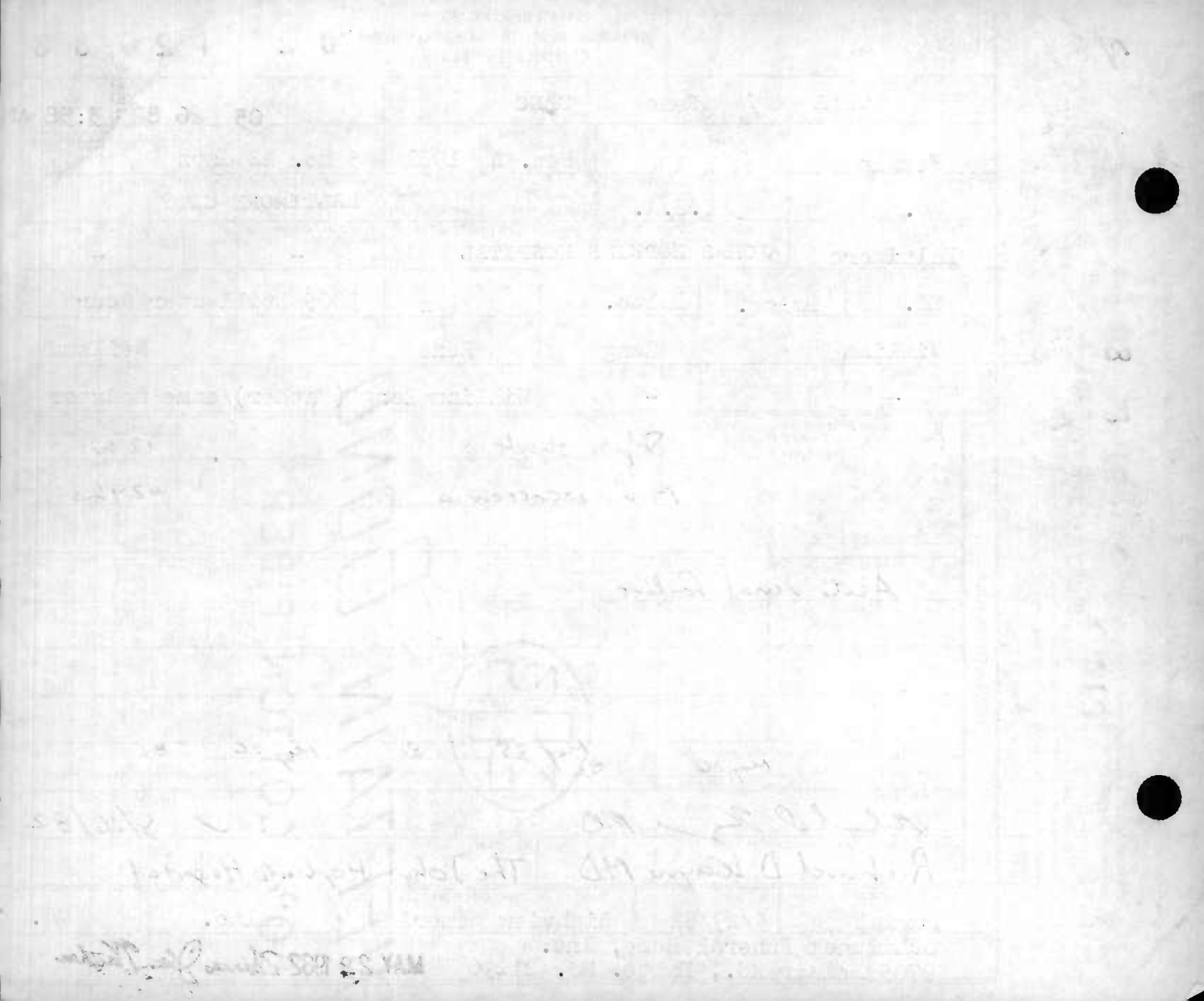
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 2 7 8 3 REG. NO. | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TARA Rene ZANG | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 26 82 | | | |
| 3. SEX Female | | | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 4 1981 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 5 mo. 22 days | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Md. Balto. Balto. 3005 Stillwater Court | | 14. FATHER'S NAME FIRST MIDDLE LAST William Zang | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rene Neilson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) - | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS William Zang (father) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF (b) Meningococemia DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs ~24 hrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Acute renal failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 25 , 19 82 , to May 26 , 19 82 , that (I) (we) last saw the deceased alive on May 26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard D. Kayne MD | | | | DEGREE | | 22c. DATE SIGNED 5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard D. Kayne MD | | | | 22e. ADDRESS The Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Highview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1982 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the medical examiner must be notified or the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 1 2 7 8 4 | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ELLA D. ZEINOG | | | | | 2a. DATE OF DEATH MONTH 5 DAY 27 YEAR 82 | | | | | 2b. HOUR 7:55 AM |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 6 DAY 11 YEAR 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS. HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 205 Mountain Rd. #21090 | | |
| 14. FATHER'S NAME FIRST Robert MIDDLE Blum LAST Meta | | | | | 15. MOTHER'S MAIDEN NAME FIRST Meta MIDDLE Godecke LAST Godecke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 218-09-4386 | | 17. INFORMANT 522 Lake View Circle, Severna Park, Md. 21146 Mr. Richard F. Zeinog, Jr. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia 2089 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/11/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Leukemia | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR AM MONTH 5 DAY 11 YEAR 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET 205 Mountain Rd. CITY OR TOWN Severna Park COUNTY Anne Arundel STATE Md. | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/11/82 to 5/27/82 , that (we) last saw the deceased alive on 5/27/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE David C. Allen DEGREE MD | | | | | 22c. DATE SIGNED 5/27/82 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID C. ALLEN, M.D. | | |
| 22e. ADDRESS 201 E. UNIVERSITY PARKWAY | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 29, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 23d. LOCATION CITY OR TOWN Balto. COUNTY Md. | | 23e. STATE Md. | | |
| 24. FUNERAL DIRECTOR C. Truman Schwab, P.A. 3512 Frederick Ave. #2122975 | | | | | | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 7 8 5

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| FOR 1. STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IGNATIUS ZILL | | 2a. DATE OF DEATH MONTH DAY YEAR 5-16-82 | | 2b. HOUR 8⁰⁰ P.M. | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3-6-91 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 91 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE SQUARE NURSING CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George ZILL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ✓ | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ✓ | | 16b. SOCIAL SECURITY NO. ✓ | |
| 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 DUE TO, OR AS A CONSEQUENCE OF (b) old CVA DUE TO, OR AS A CONSEQUENCE OF (c) No paralyt 413 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 415. | | PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) H/O pneumonia 2 yrs ago | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/82 to 5/13/82 , that (I) (we) lost saw the deceased alive on 5/13/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE W.M. Maerem | | 22c. DATE SIGNED 5/17/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMATUN N MAEREM | | 22e. ADDRESS 501 Dolphin St, Baltimore | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE 6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY W.B. Cullen Co. | | 23d. LOCATION CITY OR TOWN COUNTY STATE A.A. County Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Samuel 1712-18 W. North La | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

John W. McQuay
J. W. McQuay

1890

1891

1892

1893

1894

BP 13
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. <u>8 2 1 2 7 8 6</u> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <u>Mary</u> | | MIDDLE <u>A.</u> | | LAST <u>ZINKAND</u> | | 2a. DATE OF DEATH MONTH DAY YEAR <u>May 18, 1982</u> | | 2b. HOUR <u>2:05</u> ^P _M | |
| 3 SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>January 28, 1904</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Maryland General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Howard</u> | | 13c. CITY OR TOWN <u>Ellicott City</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>5533 Montgomery Road</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>John T. Brennan</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Agnes Keaning</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>214-56-7615</u> | | 17. INFORMANT <u>Frances Luken</u> | | | | ADDRESS <u>Same as # 13</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis = SEPSIS</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia = PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Stroke = Cerebrovascular accident</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 80</u> to <u>5-18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Harold Bobb</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <u>5/18/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harold Bobb, M.D.</u> | | | | 22e. ADDRESS <u>7220 Park Heights Ave., Balto., MD. 21208</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/21/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Witzke Funeral Home</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 21 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |
| 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | | | |

MEDICAL CERTIFICATION

May 12, 1968

at 10:00

10:00

Washington City

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

X

NOTICE



Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital

Marine General Hospital